MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

EMERGENCY MEDICAL SERVICES

COMMISSION MEETING MINUTES

DATE: December 12, 2014

LOCATION: Brownsburg Fire Territory
470 E Northfield Drive
Brownsburg, IN 46112

MEMBERS PRESENT:	John Zartman	(Training Institution)
	Charles Valentine	(Municipal Fire)
	Myron Mackey	(EMTs)
	Mike Garvey	(Indiana State EMS Director)
	Michael Lockard	(General Public)
	G. Lee Turpen II	(Private Ambulance)
	Darin Hoggatt	(Paramedics)
	Stephen Champion	(Medical Doctor)
	Michael Olinger	(EMS State Medical Director)
MEMBERS ABSENT:		
	Sue Dunham	(Emergency Nurses)
	Melanie Jane Craigin	(Hospital EMS)
	Terri Hamilton	(Volunteer EMS)

OTHERS PRESENT: Field Staff (Robin Stump, Don Watson, Steve Gressmire and Elizabeth Westfall), Candice Hilton, and members of the EMS Community.

CALL TO ORDER AND ROLL CALL

Meeting called to order at 10:03am by Chairman Lee Turpen. Chairman Turpen announced that there would be two changes to the agenda: EMS for Children would be replaced with a presentation from Greg Poe for Mission Lifeline with the American Heart Association and that US Steel would make a presentation between the IEMSA report and the Personnel Waiver requests.

HONORARY CERTIFICATION

a. Craig Brittingham (see attachment #1)

Mr. Jason Smith read into record the letter requesting the posthumous honorary AEMT certification for Mr. Brittingham.

A motion was made by Commissioner Mackey to grant the honorary AEMT certification. The motion was seconded by Commissioner Zartman. The motion passed. The certification was presented to family by Chairman Turpen.

b. Nate Mills (see attachment #2)

Mr. Jason Smith read into record the letter requesting the honorary paramedic license for Mr. Mills.

A motion was made by Commissioner Zartman to grant the honorary paramedic license. The motion was seconded by Commissioner Hoggatt. The motion passed. EMS State Director Michael Garvey presented the license to Commissioner Zartman who will be delivering the license to Mr. Mills at a later date.

c. Judith Shulock (see attachment #3)

Mr. Jason Smith read into record the letter requesting the honorary paramedic license for Ms. Shulock.

A motion was made by Commissioner Valentine to grant the honorary paramedic license. The motion was seconded by Commissioner Lockard. The motion passed. Mr. Thomas Fentress accepted the honorary paramedic license for Ms. Shulock

ADOPTION OF MINUTES

a. August 20, 2014 minutes

A motion was made by Commissioner Mackey to accept the minutes as written. The motion was seconded by Commissioner Zartman. The motion passed.

b. October 17, 2014

A motion was made by Commissioner Mackey to accept the minutes as written. The motion was seconded by Commissioner Hoggatt. The motion passed.

INDIANA DEPARTMENT OF HEALTH

a. Trauma Registry (see attachment #4)

Ms. Katie (Gatz) Hokanson presented the Trauma registry report

b. "In process" process and one year process report (see attachment #5)

Mr. Art Logsdon presented the new forms and changes for the "in process" application for level III trauma centers. Dr. Reed from IU Health Methodist was also present to answer questions from the Commission. Discussion followed regarding the changes on the form.

A motion was made by Commissioner Valentine to approve the new level III trauma "in the process" application with the changes. The motion was seconded by Commissioner Lockard. The motion passed.

A motion was made by Commissioner Valentine to approve the One Year Progress report for "in the process" Level III Trauma Center application. The motion was seconded by Commissioner Zartman. The motion passed.

AMERICAN HEART ASSOCIATION – MISSION LIFELINE

Mr. Greg Poe briefly went back over the requirements for Mission Lifeline initiative awards for provider organizations and brought more awareness of Mission Lifeline. The requirements and nomination forms can be found at www.aha.com .

Chairman Turpen encouraged providers to participate in Mission Lifeline and Cares.

TECHNICAL ADVISORY COMMITTEE (TAC)

Chairman of the TAC Mr. Leon Bell reported regarding the TAC recommendations and meeting.

a. Chairman Bell stated that he would like to remind the Commission that it is time to form the subcommittee to review the PI manual. The Commission passed the TAC recommendation for the formation of the sub-committee back in August of this year.

By chairman's direction Chairman Turpen directed Chairman Bell to ask for two members of the TAC to volunteer for the subcommittee.

b. Chairman Bell asked for passage of the final portion of the PI manual, the State Rep section, as recommended by the TAC. Chairman Bell also asked for the State Rep section not be read into record because of some of the information that it contains.

A motion was made by Commissioner Zartman to approve the State Rep section of the PI manual as recommended by the TAC. The motion was seconded by Commissioner Valentine. The motion passed.

c. Chairman Bell also announced the resignation of Dr. Edward Bartkus and Ms. Tina Butt from the TAC. Chairman Bell asked that the Commission start the process to fill the vacant positions on the TAC. Chairman Turpen asked to have the TAC application posted on the web site.

INDIANA EMERGENCY MEDICAL SERVICES ASSOCIATION (IEMSA)

Mr. Faril Ward reported for IEMSA. IEMS has a board meeting on Tuesday December 2nd. Mr. Ward announced that the IEMSA's conference will be June 5th and 6th in association with IU Health. Mr. Ward announced the legislative breakfast will be held on January 29th among the items to be discussed will be death benefits for EMS and green light permit regulations. Members of IEMSA met with the director of Indiana Medicaid and started working with Indiana Medicaid to improve the process of reimbursements.

PERSONNEL WAIVER REQUESTS

Joe Sheets from US Steel gave a presentation regarding US Steel operations and EMS operations. Some discussion followed concerning the waivers requested by US Steel. The following US Steel workers requested a waiver of Emergency Rule LSA Document #12-393(E) Section 49 (f)which states advanced emergency medical technicians shall: (1) not perform a procedure for which the advanced emergency medical technician has not been specifically trained: (A) in the Indiana emergency medical technician basic and the Indiana advanced emergency medical technician curriculums; or (B) that has not been approved by the commission as being within the scope and responsibility of the advanced emergency medical technician; The following individuals are requesting a waiver to use the Morgan lens (Approved October 2014), CPAP and the following medications while working at the United States Steel facility: Cyanokit , Epinephrine 1:10,000, Toradol, Zogran ODT, Atrovent,. Staff Recommends: (Tabled from last meeting for CPAP and medications) ADD Ryan Samanas for CPAP and medications listed above.

Jeff Szostek , Kevin Stumpe, Deborah Petersen, Nicholas Gillund, Ryan Balko
Robert Engelhardt, Ediz Null, Melanie Bales, and Ryan Samanas

A motion was made by Commissioner Zartman to approve the request to allow US Steel to perform advanced skills, for the use of the Cyanokit, Epi 1:10,000,Toradol, Zofran, and Atrovent, and also included from a previous waiver, the Morgan Lens and CPAP. These skills may ONLY be performed on US Steel property, ONLY on US Steel personnel, or US Steel Contracted employees. If treatment is rendered, with any of the additional skills listed above, the patient must be transported by US Steel EMS to the closest, most appropriate, hospital for continued medical care. This waiver is ONLY for the responses / incidents that originate on US Steel property. Any EMS responses made by US Steel EMS outside US Steel Private property or any initial or dual responses on any public property for any type of mutual aid with other services, US Steel EMS must perform to the standardized Indiana State Advanced EMT scope of practice at all times. It was encouraged that US Steel evaluate their current response structure to see if advancing to the Paramedic level certification is warranted, as this waiver is for a 2 year period, with progress reports every 6 months. The motion was seconded by Commissioner Hoggatt. The motion passed.

The following requested a waiver of 836 IAC 4-9-5, "Continuing education requirements," which states(a) To renew a certification, a certified paramedic shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements in subsection (b). (b) An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following: (1) Section IA, forty-eight (48) hours of continuing education through a formal paramedic refresher course as approved by the commission or forty-eight (48) hours of supervising hospital-approved continuing education that includes the following: (A) Sixteen (16) hours in airway, breathing, and cardiology. (B) Eight (8) hours in medical emergencies.(C) Six (6) hours in trauma. (D) Sixteen (16) hours in obstetrics and pediatrics. (E) Two (2) hours in operations. (2) Section IB, attach a current copy of cardiopulmonary resuscitation certification for the professional rescuer. The certification expiration date shall be concurrent with the paramedic certification expiration date. (3) Section IC, attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the paramedic certification expiration date. (4) Section II, twenty-four (24) additional hours of emergency medical services related continuing education; twelve (12) of these hours shall be obtained from audit and review. The participation in any course as approved by the commission may be included in this section. (5) Section III, skill maintenance (with no specified hour requirement). All skills shall be directly observed by the emergency medical service medical director or

emergency medical service educational staff of the supervising hospital either at an in-service or in an actual clinical setting. The observed skills include, but are not limited to, the following: (A) Patient medical assessment and management. (B) Trauma assessment and management. (C) Ventilatory management. (D) Cardiac arrest management. (E) Bandaging and splinting. (F) Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy. (G) Spinal immobilization. (H) Obstetrics and gynecological scenarios. (I) Communication and documentation.

Tabitha Alvarado – 8016-8880, is requesting a waiver of 3 months to allow more time to acquire continuing education hours. Currently working on hours on line but is registering for a paramedic refresher course in February through St. Vincent Hospital. There is a letter attached showing hardship. Paramedic expired 12/31/2014. Staff recommends: approve of the 90 days to finish in-service and recertify.

Tabitha L. Alvarado - Paramedic

A motion was made by Commissioner Zartman to approve the waiver for ninety (90) days. The motion was seconded my Commissioner Olinger. The motion passed.

The following request a waiver of 836 IAC 4-9-6, "Paramedic certification based upon reciprocity," which states(a) To obtain paramedic certification based upon reciprocity, an applicant shall be affiliated with a certified paramedic provider organization and be a person who, at the time of applying for reciprocity, meets one (1) of the following requirements: (1) Possesses a valid certificate or license as a paramedic from another state and who successfully passes the paramedic practical and written certification examinations as set forth and approved by the commission. Application for certification shall be postmarked or delivered to the agency office within six (6) months after the request for reciprocity. (2) Has successfully completed a course of training and study equivalent to the material contained in the Indiana paramedic training course and successfully completes the written and practical skills certification examinations prescribed by the commission. (3) Possesses a valid National Registry paramedic certification. (b) Notwithstanding subsection (a), any nonresident of Indiana who possesses a certificate of license as a paramedic that is valid in another state, upon residing at an Indiana address, may apply to the agency for temporary certification as a paramedic. Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification that shall be valid for: (1) the duration of the applicant's current certificate or license; or (2) a period not to exceed six (6) months from the date that the reciprocity request is approved by the director; whichever period of time is shorter. A person receiving temporary certification may apply for full certification using the procedure required in section 1 of this rule.

Matthew Kehn – 5933-6260 is requesting more time on his 6 month temporary that was issued on April 17, 2014 and expires on December 16, 2014. Mr. Kehn is requesting 90 day more to test the written portion of the National Registry exam. Mr. Kehn has passed his skills exam and taken the written twice and failed. He is currently reading through a different paramedic course book as study material. Staff recommends: Denial based on past Commission history. He is still eligible to finish testing to get his NR but would not be certified with a temp in Indiana.

Matthew Aaron Kehn – EMT

The motion was made by Commissioner Valentine to approve the waiver for sixty (60) days from today (December 12, 2014). The motion was seconded by Commissioner Lockard. Discussion followed. Mr. Kehn was present and answered question from the Commission members. Commissioner Valentine amended his motion to approve the waiver for ninety (90) day from today (December 12, 2014). The motion was seconded by Commissioner Lockard. The motion passed.

The following requested a waiver of 836 IAC 4-4-1 "General certification provisions'" which states(a) Applicants for original certification as an emergency medical technician shall meet the following requirements: (1) Be a minimum of eighteen (18) years of age. (2) Successfully complete the Indiana basic emergency medical technician training course as approved by the commission and administered by a certified training institution. (3) Pass the emergency medical technician written and practical skills examinations as set forth and approved by the commission. (b) The applicant shall apply for certification on forms provided by the agency postmarked within one (1) year of the date that the course was concluded as shown on the course report. (c) The minimum requirement for basic emergency medical technicians training shall be as follows: (1) The current version of the Indiana basic emergency medical technician training course as amended and approved by the commission (2) Each Indiana basic emergency medical technician course shall be supervised by a program director who is affiliated with the course sponsoring training institution as described in this article. (d) No course shall be approved as equivalent to subsection (c) unless the course meets the training standards in effect on the date an equivalency determination is requested. (e) Emergency medical technicians shall comply with the following: (1) An emergency medical technician shall not perform procedures for which the emergency medical technician has not been specifically trained: (A) in the Indiana basic emergency medical technician curriculum; and (B) that have not been approved by the commission as being within the scope and responsibility of the emergency medical technician. (2) An emergency medical technician shall not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or the members of the general public. (3) An emergency medical technician shall comply with the state and federal laws governing the confidentiality of patient medical information. (4) An emergency medical technician shall not delegate to a less qualified individual any skill that requires an emergency medical technician. (5) An emergency medical technician shall comply with the protocols established by the commission, the provider organization, and the provider organization's medical director.

April Murphy-Shelton – 2036-9291 is requesting more time to complete her written test. She completed her EMT Course in September 2013. She completed and passed her practical also in September 2013. Her one year was up September 18, 2014. Staff recommends: approval of 90 days to complete and pass the written exam.

April Murphy-Shelton – EMT

A motion was made by Commissioner Valentine to approve the waiver for ninety (90) days from today (December 12, 2014). The motion was seconded by Commissioner Champion. The motion passed.

The following requested a waiver of LSA Document # 12-393(E), Section 32(b) which states (b) Application for emergency medical technician certification shall be made on forms provided by the agency. Applicants shall complete the required forms and submit the forms to the agency. The application shall include the following: (1) The name and address of the applicant. (2) Criminal history declarations of the applicant. (3) The name of the training institution where training was completed. (4) Other information required by the agency. (c) All applicants for original certification shall provide evidence of compliance with the requirements for certification. (d) Certification as an emergency medical technician shall be valid for a period of two (2) years. (e) To renew a certification, a certified emergency medical technician shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirement to take and report forty (40) hours of continuing education according to the following: (1) Participate in a minimum of thirty-four (34) hours of any combination of: (A) lectures; (B) critiques; (C) skills proficiency examinations; (D) continuing education courses; or (E) teaching sessions; that review subject matter presented in the Indiana basic emergency medical technician curriculum. (2) Participate in a minimum of six (6) hours of audit and review. (3) Participate in any update course as required by the commission. (4) Successfully complete a proficiency evaluation that tests the skills presented in the Indiana basic emergency medical technician curriculum. (f) If a properly completed renewal application is submitted within one hundred twenty (120) calendar days after the expiration of the certification, together with the required documentation to show that the applicant has completed all required continuing education within the two (2) years prior to the expiration of the certification, and a fifty dollar ($50) reapplication fee, the certification will be reinstated on the date that the commission staff determines that the required application, documentation, and reapplication fee have been properly submitted. The expiration date will be two (2) years from the expiration of the previous, expired certification. (g) Notwithstanding any other provisions of this article, a person also certified as an emergency medical technician-basic advanced, emergency medical technician-intermediate, advanced emergency medical technician, or paramedic under IC 16-31 may substitute the required continuing education credits for those of subsection (e). (h) An individual who fails to comply with the continuing education requirements described in this article shall not exercise any of the rights and privileges of an emergency medical technician and shall cease from providing the services authorized by an emergency medical technician certification as of the date of expiration of the current certificate. (i) An individual wanting to reacquire a certification shall: (1) complete an emergency medical technician recertification training course as approved by the commission; and (2) successfully complete the state written and practical skills examinations as set forth and approved by the commission. If the individual fails either certification examination, the person must retake an Indiana basic emergency medical technician training course.

Katrina Shields is requesting more time to complete her required in-service training for EMT. EMT certification expired September 30, 2014. Staff recommends: Denial based on past Commission history. Per the rules she is eligible to retest practical and written to obtain EMT certification based on previous certification

Katrina Shields – EMT

A motion was made by Commissioner Zartman to deny the waiver request. The motion was seconded by Commissioner Valentine. The motion passed.

PROVIDER WAIVER REQUESTS

The following requested a waiver of LSA Document # 12-393(E), Section 19 which states(b) Any organization providing, or seeking to provide, rotorcraft ambulance services utilizing rotorcraft aircraft is required to be certified as an advanced life support rotorcraft ambulance service provider organization by the commission. The advanced life support rotorcraft ambulance service provider organization shall be certified in accordance with 836 IAC 3 and SECTIONS 18 through 22 of this document *[SECTION 18 of this document, this SECTION, and SECTIONS 20 through 22 of this document]* under IC 16-31 as appropriate. (c) The provider organization of rotorcraft ambulance services shall ensure that the aircraft used in conjunction with the provision of advanced life support services meets the guidelines as specified 836 IAC 3 and SECTIONS 18 through 22 of this document *[SECTION 18 of this document, this SECTION, and SECTIONS 20 through 22 of this document]* under IC 16-31 and is certified by the commission. Each rotorcraft ambulance service provider organization shall meet all applicable parts of F.A.A. regulation and shall hold a valid 14 CFR 135 air carrier certificate or shall have a contract with the holder of a 14 CFR 135 air carrier certificate to provide aviation services under their certificate. Either must also have current F.A.A. approved air ambulance operations specifications. (d) Advanced life support rotorcraft ambulance service provider organizations will have an agreement with one (1) or more supervising hospitals for the following services: (1) Continuing education. (2) Audit and review. (3) Medical control and direction. (4) Provide liaison and direction for supply of medications, fluids, and other items utilized by the provider organization. (5) Safety and survival programs and education. The agreement shall include a detailed description of how such services will be provided to the advanced life support rotorcraft ambulance service provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with an advanced life support rotorcraft ambulance service provider organization as a supervising hospital, an interhospital agreement will be provided to the commission that clearly defines the specific duties and responsibilities of each hospital to ensure medical, safety, and administrative accountability of system operation. An agreement is not required when the hospital and the provider are the same organization. (e) The advanced life support rotorcraft ambulance service provider organization will have an air-medical director provided by the advanced life support rotorcraft ambulance service provider organization, or jointly with the supervising hospital, who has knowledge of air transport problems and flight physiology. The air-medical director is responsible for providing competent medical direction and overall supervision of the medical aspects of the advanced life support rotorcraft ambulance service provider organization. The duties and responsibilities of the air-medical director include, but are not limited to, the following: (1) Assuming all medical control and authority over any and all patients treated and transported by the rotorcraft ambulance service. (2) Providing liaison with physicians. (3) Assuring that the drugs, medications, supplies, and equipment are available to the advanced life support rotorcraft ambulance service provider organization. (4) Monitoring and evaluating overall medical operations. (5) Assisting in the coordination and provision of continuing education. (6) Providing information concerning the operation of the advanced life support rotorcraft ambulance service provider organization to the commission. (7) Providing individual consultation to the air-medical personnel. (8) Participating on the medical control committee of the supervising hospital in at least quarterly audit and review of cases treated by air-medical personnel. (9) Attesting to the competency of air-medical personnel affiliated with the advanced life support rotorcraft ambulance service provider organization. (10) Designating an individual or individuals to assist in the performance of these duties. (f) Each rotorcraft ambulance service provider organization will designate one (1) person to assume

responsibility for inservice training. This person shall be licensed as a paramedic, a registered nurse, or a licensed physician and actively provide patient care during air ambulance transport. (g) A rotorcraft ambulance service provider organization shall not engage in conduct or practices detrimental to the health and safety of emergency patients or to members of the general public while in the course of business or service as a rotorcraft ambulance service provider organization. (h) The advanced life support rotorcraft ambulance service provider organization shall have an area wide plan to provide safety education and coordinate rotorcraft ambulance service with emergency medical services rescue, law enforcement, mutual aid backup systems, and central dispatch when available. (i) Each advanced life support rotorcraft ambulance service provider organization shall do the following: (1) Maintain an adequate number of trained personnel and aircraft to provide continuous twenty-four (24) hour advanced life support services. (2) Notify the agency in writing within thirty (30) days of a paramedic's affiliation or termination of employment, or for any reason that has prohibited a licensed individual from performing the procedures required of a paramedic under 836 IAC 2 and SECTIONS 11 through 17 of this document. (j) Each rotorcraft ambulance service provider organization shall designate one (1) person to assume the responsibilities for establishment of a safety committee consisting of the following: (1) Pilot or pilots. (2) Air-medical personnel. (3) Aircraft maintenance technician or technicians. (4) Communications personnel. The safety committee shall meet at least quarterly and may be concurrent and in conjunction with the audit/review committee.

Air Methods – Kentucky is requesting to waive the rule that requires the supervising hospital to be a hospital licensed under Indiana Code. They are currently licensed under Kentucky and meet all the requirements. Staff recommends approval. Hospital is currently meeting all the other rules required.

Air Methods- Kentucky University of Louisville

A motion was made by Commissioner Valentine to approve this waiver request. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of LSA Document # 12-393(E), Section 19 which states(b) Any organization providing, or seeking to provide, rotorcraft ambulance services utilizing rotorcraft aircraft is required to be certified as an advanced life support rotorcraft ambulance service provider organization by the commission. The advanced life support rotorcraft ambulance service provider organization shall be certified in accordance with 836 IAC 3 and SECTIONS 18 through 22 of this document *[SECTION 18 of this document, this SECTION, and SECTIONS 20 through 22 of this document]* under IC 16-31 as appropriate. (c) The provider organization of rotorcraft ambulance services shall ensure that the aircraft used in conjunction with the provision of advanced life support services meets the guidelines as specified 836 IAC 3 and SECTIONS 18 through 22 of this document *[SECTION 18 of this document, this SECTION, and SECTIONS 20 through 22 of this document]* under IC 16-31 and is certified by the commission. Each rotorcraft ambulance service provider organization shall meet all applicable parts of F.A.A. regulation and shall hold a valid 14 CFR 135 air carrier certificate or shall have a contract with the holder of a 14 CFR 135 air carrier certificate to provide aviation services under their certificate. Either must also have current F.A.A. approved air ambulance operations specifications. (d) Advanced life support rotorcraft ambulance service provider organizations will have an agreement with one (1) or more supervising hospitals for the following services: (1) Continuing education. (2) Audit and review. (3) Medical control and direction (4) Provide liaison and direction for supply of medications, fluids, and other items utilized by the provider organization. (5)

Safety and survival programs and education. The agreement shall include a detailed description of how such services will be provided to the advanced life support rotorcraft ambulance service provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with an advanced life support rotorcraft ambulance service provider organization as a supervising hospital, an interhospital agreement will be provided to the commission that clearly defines the specific duties and responsibilities of each hospital to ensure medical, safety, and administrative accountability of system operation. An agreement is not required when the hospital and the provider are the same organization. (e) The advanced life support rotorcraft ambulance service provider organization will have an air-medical director provided by the advanced life support rotorcraft ambulance service provider organization, or jointly with the supervising hospital, who has knowledge of air transport problems and flight physiology. The air-medical director is responsible for providing competent medical direction and overall supervision of the medical aspects of the advanced life support rotorcraft ambulance service provider organization. The duties and responsibilities of the air-medical director include, but are not limited to, the following: (1) Assuming all medical control and authority over any and all patients treated and transported by the rotorcraft ambulance service. (2) Providing liaison with physicians. (3) Assuring that the drugs, medications, supplies, and equipment are available to the advanced life support rotorcraft ambulance service provider organization. (4) Monitoring and evaluating overall medical operations. (5) Assisting in the coordination and provision of continuing education. (6) Providing information concerning the operation of the advanced life support rotorcraft ambulance service provider organization to the commission. (7) Providing individual consultation to the air-medical personnel. (8) Participating on the medical control committee of the supervising hospital in at least quarterly audit and review of cases treated by air-medical personnel. (9) Attesting to the competency of air-medical personnel affiliated with the advanced life support rotorcraft ambulance service provider organization. (10) Designating an individual or individuals to assist in the performance of these duties. (f) Each rotorcraft ambulance service provider organization will designate one (1) person to assume responsibility for inservice training. This person shall be licensed as a paramedic, a registered nurse, or a licensed physician and actively provide patient care during air ambulance transport. (g) A rotorcraft ambulance service provider organization shall not engage in conduct or practices detrimental to the health and safety of emergency patients or to members of the general public while in the course of business or service as a rotorcraft ambulance service provider organization. (h) The advanced life support rotorcraft ambulance service provider organization shall have an areawide plan to provide safety education and coordinate rotorcraft ambulance service with emergency medical services rescue, law enforcement, mutual aid backup systems, and central dispatch when available. (i) Each advanced life support rotorcraft ambulance service provider organization shall do the following: (1) Maintain an adequate number of trained personnel and aircraft to provide continuous twenty-four (24) hour advanced life support services. (2) Notify the agency in writing within thirty (30) days of a paramedic's affiliation or termination of employment, or for any reason that has prohibited a licensed individual from performing the procedures required of a paramedic under 836 IAC 2 and SECTIONS 11 through 17 of this document (j) Each rotorcraft ambulance service provider organization shall designate one (1) person to assume the responsibilities for establishment of a safety committee consisting of the following: (1) Pilot or pilots. (2) Air-medical personnel. (3) Aircraft maintenance technician or technicians. (4) Communications personnel. The safety committee shall meet at least quarterly and may be concurrent and in conjunction with the audit/review committee.

Air Methods/UCAN is requesting several waivers of the emergency rules. #1 UCAN is requesting to waive the rule that requires the air ambulance medical director to be a licensed physician in Indiana. Staff recommends: approval, UCAN provides a critical service in Indiana and the MD is licensed in IL. #2 UCAN

is requesting to waive the rule that requires the supervising hospital to be a hospital licensed under Indiana Code. They are currently licensed under Illinois and meet all the requirements. Staff recommends: approval. The hospital is certified as a hospital in Illinois and meets the remaining requirement per our rules.

Air Methods – University of Chicago (UCAN)

A motion was made by Commissioner Valentine to approve the waiver concerning having an Indiana Licensed Medical Director for this provider organization. The motion was seconded by Commissioner Hoggatt. The motion passed.

A motion was made by Commissioner Valentine to approve the waiver concerning the supervising hospital waiver request. The motion was seconded by Commissioner Hoggatt. The motion passed.

The following requested a waiver of 836 IAC 1-4-2 "Emergency medical services vehicle radio equipment," which states (a) All communication used in emergency medical service vehicles for the purpose of dispatch or tactical communications shall demonstrate and maintain the ability to provide a voice communications linkage with the emergency medical service provider organization's dispatch center within the area that the emergency medical service provider organization normally serves or proposes to serve. (b) Communication equipment used in emergency medical services vehicles shall be appropriately licensed through the Federal Communications Commission, when applicable. The maximum power of the transmitter shall be not more than the minimum required for technical operation, commensurate with the: (1) size of the area to be served; and (2) local conditions that affect radio transmission and reception. (c) All emergency medical services vehicles shall be equipped with two (2) channels or talk-groups as follows: (1) One (1) channel or talk-group shall be used primarily for dispatch and tactical communications. (2) One (1) channel or talk-group shall be 155.340 MHz and have the proper tone equipment to operate on the Indiana Hospital Emergency Radio Network (IHERN) unless the provider organization vehicles and all the destination hospitals within the operational area of the provider organization have a system that is interoperable with the Indiana statewide wireless public safety voice and data communications system.

Cincinnati Children's Hospital is requesting a renewal of a waiver for the requirement for the IHERN communications. They currently do all communication by cell phone. They do not do 911 calls or mutual aid calls. Staff recommends: Approval

Cincinnati Children's Hospital

A motion was made by Commissioner Olinger to approve the waiver request. The motion was seconded by Commissioner Valentine. The motion passed.

The following requested a waiver of LSA Document # 12-393(E), Section 16 which states (b) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa)

albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin

D & S Ambulance is requesting a waiver of the equipment and medications in the Intermediate rules. D & S Ambulance has new ADV EMTs and are certified at the ALS level. Currently our rules do not have ADV EMT so the provider needs to follow the rules at the intermediate level. Staff recommends: Approval

D & S Ambulance

A motion was made by Commissioner Valentine to approve the waiver request. The motion was seconded by Commissioner Lockard. The motion passed

The following requested a waiver of LSA Document # 12-393(E), Section 14 which states (g) The emergency medical technician-intermediate provider organization shall do the following:(1) Maintain a communications system that shall be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission. (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. (3) Notify the commission in writing within thirty (30) days of assigning any individual to perform the duties and responsibilities required of an advanced emergency medical technician-intermediate. This notification shall be signed by the provider organization and medical director of the provider organization.

D & S Ambulance is requesting a Staffing Waiver to maintain 24 hour coverage. Staff recommends: approval - with the stipulation of reporting to the agency the following: 6 month update and e-mail to area district manager each time this occurs.

D & S Ambulance

A motion was made by Commissioner Hoggatt to approve the waiver request for six (6) months and that the service report to their district manager every time they have to use this waiver. The motion was seconded by Commissioner Valentine. The motion passed.

The following requested a waiver of LSA Document # 12-393(E), Section 16 which states (b) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii)

Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin.

Franklin County EMS is requesting a waiver of the equipment and medications in the Intermediate rules. Franklin County EMS has new ADV EMTs and is moving to the ALS level. Currently our rules do not have ADV EMT so the provider needs to follow the rules at the intermediate level. Staff recommends: Approval

Franklin County EMS

A motion was made by Commissioner Valentine to approve the waiver. The motion was seconded by Commissioner Lockard. The motion passed.

The following requested a waiver of LSA Document # 12-393(E), Section 14 which states (g) The emergency medical technician-intermediate provider organization shall do the following: (1) Maintain a communications system that shall be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission. (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. (3) Notify the commission in writing within thirty (30) days of assigning any individual to perform the duties and responsibilities required of an advanced emergency medical technician-intermediate. This notification shall be signed by the provider organization and medical director of the provider organization.

Franklin County EMS is requesting a Staffing Waiver to maintain 24 hour coverage. They have 6 people that are currently in the testing process. Staff recommends: approval - with the stipulation of reporting to the agency the following: 6 month update and e-mail to area district manager each time this occurs.

Franklin County EMS

A motion was made by Commissioner Lockard for six (6) months and report to their district manager every time they have to use this waiver. The motion was seconded by Commissioner Hoggatt. The motion passed.

The following requested a waiver of LSA Document # 12-393(E), Section 16 which states (B) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin.

Riley Fire Department is requesting a waiver of the equipment and medications in the Intermediate rules for ALS non-transport vehicles. Riley Fire Department has new ADV EMTs and is moving up to the ALS level. They will also have an ambulance certified at the paramedic level. Staff recommends: Approval since Riley will be moving to the paramedic level, they will have an ambulance certified at the paramedic level but are going to be certifying their engines as ALS non-transport and will equip them for ADV EMT level.

Riley Fire Department

A motion was made by Commissioner Valentine to approve the waiver request. The motion was seconded by Commissioner Hoggatt. The motion passed.

The following requested a waiver of the following requested a waiver of LSA Document # 12-393(E), Section 14 which states (g) The emergency medical technician-intermediate provider organization shall do the following: (1) Maintain a communications system that shall be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission. (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. (3) Notify the commission in writing within thirty (30) days of assigning any individual to perform the duties and responsibilities required of an advanced emergency medical technician-intermediate. This notification shall be signed by the provider organization and medical director of the provider organization.

Riley Fire Department

After discussion it was determined that this waiver was not needed due to Riley already being a Paramedic Organization and already providing ALS coverage 24/7.

Chairman Turpen called for a break at 11:35am

Chairman Turpen called the meeting back to order at 11:47am

OLD BUSINESS

a. Tactical EMS (TEMS)
Commissioner Valentine presented the TEMS work group information. The work group has been working on the recommendations for three (3) months. The group consisted of fire, EMS and law enforcement people. The group broke down TEMS into three sections: curriculum, tactical Medical Director, and tactical EMS provider.

The following recommendations were made:

Curriculum:
The approved training curriculum for tactical emergency medical service shall be based on the National Association of EMT Tactical Combat Casualty Care training curriculum as amended and approved by the commission. A certified training institution shall administer the tactical EMS training and make application on approved forms. The certified training institution shall complete a report of training for those individual attending the training. Those individuals passing the NAEMT TCCC curriculum shall have that training entered into the Acadis as a record of training. **This is not a state certification.**

Tactical Medical Director:

The tactical medical director is defined as: "Board Certified Physician with an unlimited License to practice medicine in the State of Indiana who routinely manages patients who experience acute traumatic injuries". **The tactical medical director is responsible for**: Determining the tactical EMS agencies scope of practice to be used in a tactical environment. Shall attest to the tactical EMS team members training and competency as defined in the tactical EMS agency scope of practice. Shall participate in tactical EMS team after action reviews and reports.

Tactical EMS Provider:
Option 1: A law enforcement agency shall apply for certification as a BLS non transport provider and check the tactical EMS provider box. Complete forms for BLS non transport provider as required. In addition to:

Complete tactical medical director form
Complete personnel roster indicating tactical ems team membership
Submit a copy of scope of practice and protocols that have been approved signed and dated by the tactical medical director for the tactical ems team.

Option 2: The law enforcement agency may sign an MOU with a certified Indiana EMS provider who will then check the tactical EMS provider box. Amend their current certification to include tactical medical director form and personnel roster for the tactical EMS team. Submit a copy of scope of practice and protocols that have been approved signed and dated by the tactical medical director for the tactical ems team.

Commissioner Hoggatt thanked everyone that worked on the committee to bring these recommendations to the Commission. EMS State Director Michael Garvey thanked the work group on behalf of the State Fire Marshal James Greeson. Director Garvey stated that the committee has expressed interest in staying together to work on future tactical EMS issues.

A motion was made by Commissioner Mackey to approve the recommendations from the committee as stated above. The motion was seconded by Commissioner Zartman. The motion passed.

Chairman Turpen thanked everyone that worked on the committee to bring these recommendations to the Commission.

b. Primary Instructor Exam:
Mrs. Elizabeth Westfall presented the PI exam information to the Commission. Mrs. Westfall stated that the new Primary Instructor exam has been placed in the Acadis system and that about 23 candidates have taken the exam. At the time of Mrs. Westfall pulling exam results, the average score is 72.26% on this exam. Mrs. Westfall recommends the Primary Instructor exam be given to the TAC to be reviewed and review the scores. Commissioner Zartman suggested that a work group be formed with the TAC overseeing/coordinating the work group. Some discussion followed. Chairman of the TAC Leon Bell suggested that all individuals working with the TAC on the exam as well as the TAC members that work on the exam will sign a legal confidentiality agreement to protect the integrity of the exam.

A motion was made by Commissioner Olinger to approve the Primary Instructor exam being sent to the TAC with two additional individuals from the EMS education community as well. The motion was seconded by Commissioner Hoggatt. The motion passed.

NEW BUSINESS

a. EVENT
Mr. Garrett Hedden gave a presentation on the EVENT reporting system and the importance of the EMS community reporting incidents to EVENT (see attached presentation, attachment # 6). Chairman Turpen commented on the importance of reporting safety issues to databases like EVENT. No action required.

b. Proposed EMS Commission meeting dates for 2015 (all meetings are set to take place at Fishers Town hall except for the August 19th meeting which will be held at the Indiana Emergency Response Conference):
   i. February 20, 2015
   ii. April 17, 2015
   iii. June 19, 2015
   iv. August 19, 2015
   v. October 16, 2015
   vi. December 18, 2015

Chairman Turpen read the dates into record. The February meeting was changed from the 20th to the 13th. No further action taken. All dates will be posted on the IDHS website www.in.gov/dhs .

ADMINSTRATIVE PROCEEDINGS

1. **Administrative Orders Issued**
   a. **Personnel Orders**
      i. **One Year Probation**

Order No. 0136-2014 Jason Brown

No action required, none taken

Order No. 0158-2014 Jeremy Carpenter

No action required, none taken

Order No. 0059-2014 William J. Lynch Jr.

No action required, none taken

Order No. 0062-2014 Scott C. Marshall

No action required, none taken

Order No. 0157-2014 Glen O'Brian

No action required, none taken

Order No. 0150-2014 Brad Peter

No action required, none taken

ii. **2 Year Probations**

Order No. 0060-2014 Edward J. Connett

No action required, none taken

Order No. 0144-2014 Russell A. Dixon

No action required, none taken

Order No. 0146-2014 Brian Maxwell

No action required, none taken

Order No. 0135-2014 Jacob Sullivan

No action required, none taken

Order No. 0154-2014 Zachary Summers

No action required, none taken

Order No. 0140-2014 Leah Wittmer

No action required, none taken

iii. **Denied**

Order No. 0078-2014 Richard A. Owens

No action required, none taken

Order No. 0123-2014 Jeromy Lane Weaver

No action required, none taken

iv. **Emergency Orders**

Order No. 0063-2014 Kyle Dean Meyers

No action required, none taken

2. **Non-Final Orders**
   a. Timothy Greenlee

A motion was made by Commissioner Zartman to affirm the non-final order of dismissal for Timothy Greenlee. The motion was seconded by Commissioner Valentine. The motion passed.

b. Caleanna L Morley

A motion was made by Commissioner Zartman to affirm the non-final order for Caleanna Morley. The motion was seconded by Commissioner Lockard. The motion passed.

STAFF REPORTS

A. Data Report

Assistant Fire Marshal Robert Johnson introduced Ms. Angie Biggs as the new Fire and EMS data collection coordinator. Ms. Biggs stated that she is still receiving a lot of files that are not in the xml format so they are unusable. Commissioner Lockard stated that he has met with Ms. Biggs and Assistant Fire Marshal Johnson. Commissioner Lockard reminded the rest of the commission regarding the waiver that was approved in September 2012 requiring EMS services only the 83 NEMSIS elements and can only report in the xml format. (See attached report attachment #7).

A motion was made by Commissioner Lockard to continue the provider waiver that was approved by the Commission on for provider organization to only report the 83 NEMSIS silver data and only in the xml format until either they system is updated to the new version of NEMSIS or December 31, 2015. The motion was seconded by Commissioner Valentine. The motion passed. During discussion prior to the motion Chairman Turpen requested that the list of EMS providers that are reporting but in the wrong format be sent

to Director Garvey to give district managers. District managers are to visit the providers and find out what issues are preventing them from reporting in the xml format.

Chairman Turpen appointed Commissioner Lockard as the liaison between the Indiana State Health Department and Indiana Department of Homeland Security. Chairman Turpen also requested that Commissioner Lockard send any notes that he has made regarding the data elements that need to be changed to the Data Collection committee so they can work on the data dictionary.

B. Field Staff Report

Ms. Robin Stump reported the Indiana State Health Department will be holding Ebola meetings in District 6 and 8 the week after this meeting. District managers will send out dates as soon as they are available.

C. Certifications report (see attachment #8)

Commissioner Lockard requested that along with the provider report that vehicles at each provider level also be included in the report.

D. Training Report (see attachment #9)

Mr. Tony Pagano presented the numbers in regards to the POST course. After some discussion Chairman Turpen directed the staff to send out a mass email to inform people that they need to complete the POST and if they don't complete the POST their certification will not be renewed.

Mr. Pagano reported about regarding pass rates from the National Registry. Mr. Pagano stated he spoke to Chairman of the TAC, Leon Bell regarding the pass rate from the National Registry. TAC Chairman Bell suggested that IDHS call all the program directors together to discuss the issue. Commissioner Olinger suggested that the results for the Paramedic and AEMT programs be posted on the IDHS web site so potential students can see them.

STATE EMS MEDICAL DIRECTOR'S REPORT

Dr. Michael Olinger thanked the Commission for the opportunity to serve as State EMS Medical Director and looks forward to working with the Commission in the future.

STATE EMS DIRECTOR'S REPORT

Director Garvey thanked everyone for all of the hard work that they do every day and stated that everyone should take a moment to tell their people thank you for their hard work. Director Garvey also announced that there is a vacant position on the Commission with the resignation of Ed Gordon. The position is for someone in the volunteer fire service. Also there is a vacant position for a Trauma Physician with Dr. Olinger's change in position to the State EMS Medical Director anyone interested in these positions needs to visit the governor's website and fill out an application. Director Garvey also reminded everyone of the Friday, December 19 that the Community Paramedicine Mobile Integrated Health Care Symposium in conjunction with Rural Health Association will take place. The symposium will start at 8:30am and last until about 4:30pm. The symposium will help bring information and hopefully highlight questions that need to be answered. There will be some speakers from out of state as well as a panel discussion with people that are currently running pilot programs in Indiana. There will be a few vendors. There is room for 200 at this point we have 150 people signed up. Director Garvey wished everyone a safe and happy holiday.

CHAIRMAN'S REPORT AND DIRECTION

Chairman Turpen again encouraged anyone to attend the National Association of EMS Physician's meeting and then at the end of February the Consortium of Medical Directors State of the Sciences meeting in Dallas, Texas. Chairman Turpen encouraged everyone to take care of their employees and keep them warm. Chairman Turpen wished everyone a safe and happy holiday.

NEXT MEETING

Fishers Town Hall
One Municipal Drive
Fishers, IN 46038
February 13, 2015 starting at 10am

ADJOURNMENT

A motion was made by Commissioner Hoggatt to adjourn the meeting. The motion was seconded by Commissioner Zartman. The motion passed. The meeting was adjourned at 1:02pm.

Approved 

G. Lee Turpen II, Chairman

Attachment #1

GIBSON COUNTY AMBULANCE SERVICE

Office: Dan Alvey, Director
812-385-8967 Michelle Mason, Administrative Assistance FAX: 812-386-5127

Commissioner Turpen,

I am writing to you to request a posthumous AEMT certification be issued to Craig Brittingham PSID # 1553-8083. Craig was an AEMT for Gibson County EMS for many years and was killed in a motor vehicle accident on 10-16-14 in Daviess County while on his way to watch his daughter play in a volleyball game. Craig was dropped to an EMT-B when the new certification levels took effect this year. He completed the class that we held here at GCEMS and was in the process of retesting for the new AEMT certification. It would mean a lot to Craig's family as well as his EMS family here at Gibson County EMS if he were to be issued the certification he was working so hard to attain. As one of the instructors for his class, I know becoming an AEMT once again was very important to Craig and I think this would be a great way for all of us to honor his memory.

Sincerely,

Colton Ledbetter, NRP

Attachment #2

Hilton, Candice

From: Garvey, Mike
Sent: Monday, December 01, 2014 11:06 AM
To: Smith, Jason (DHS); Stump, Robin; Hilton, Candice
Subject: FW: Honorary Paramedic License

This goes with the Honorary Paramedic request sent in by Keith Reese for the EMS Commission meeting. Nate will be there for the meeting and we need to have a certificate prepared for presentation.

Mike

Michael S. Garvey, **EMS Director**
State Fire Marshal's Office
Indiana Department of Homeland Security
Telephone: 317/232-3983
Facsimile: 317/233-0497
mgarvey@dhs.in.gov

"EMS: Dedicated. For Life."

From: Keith Reese [mailto:Keith.Reese@cityoffortwayne.org]
Sent: Wednesday, November 26, 2014 10:59 AM
To: Garvey, Mike
Subject: RE: Honorary Paramedic License

Mike,

Nate Mills, PSID: 9429-1482, Bio:

Nate started out with a volunteer fire department in 1993. His strong desire to help others and be involved in emergency services lead to his enrolling in an Emergency Medical Technician course in 1994. Nate had his first full-time employment as an Emergency Medical Technician with Huntington County Hospital in 1996. Nate soon enrolled in a Paramedic program and became certified as a Paramedic in 1998. Nate continued with Huntington County until 2001 when he left to work with Wells County EMS. The Fort Wayne Fire Department accepted applications for firefighters in the spring of 2006 when Nate chose to take a chance and apply for one of the open positions. Nate was one of 29 individuals selected out of over 900 people testing for openings in our academy. Nate excelled in the academy and was able to assist other classmates outside the classroom so that they too could complete the long and difficult program. In the years that I have known Nate, his main focus has always been to help others in the community. Nate has always been positive and energetic in his work and service to others. Unfortunately we are losing Nate from the field due to his illness, but Nate will continue to serve his community with the lives he has already touched. It is with this in mind that I would like to see Nate recognized for the outstanding work he has performed in emergency services.

Keith O. Reese
EMS Director
FWFD
Office- 260-427-1181
Cell- 260-438-1671

Attachment #3

December 2, 2014

To Whom It May Concern,

I am writing this letter to the commission to ask for an honorary lifetime membership for a paramedic that has gone above and beyond the call of duty for more than 35 years. Judith Shulock was an active paramedic until the fall of 2014. She had to retire from what she loved due to an ongoing back problem and the health of her husband. Judith (Judy) has always given more than 100% towards being a paramedic, spent more hours than I can count assisting the paramedic programs at Methodist Hospitals, Gary IN. Judy started out as an EMT in 1979, working for Hammond Public Schools Systems. In 1983, Judy decided that she wanted to become a paramedic. Judy went on to work for East Chicago EMS as a paramedic and over the years was promoted to the rank of Training Officer, where she also oversaw the training of new hires and the captains of the dept. Judy worked at East Chicago for 28 years. She left there when The Methodist Hospitals had an opening for a paramedic on the casino boat. Judy worked 72 hours a pay period, even though she wanted part time hours. Judy would work the afternoon shift, which was a big help for scheduling and she would do it without any hesitation. Judy would work holidays, and would tell me, "I know it's hard to find coverage, and you all have young families, you should be with them."

METHODIST
HOSPITALS

When Judy came into my office to turn in her resignation, she told me "this is the hardest thing to do; I do not want to give you this letter." I did not want to accept the letter, but I knew her health was more important. The reason I did not want to accept the letter was not because of the model employee that Judy was, but because of the person she was. I meet with the Security Supervisor almost every month, and every time I would go into the office, I would have another individual tell me how wonderful Judy is. I would hear statements like, Judy is a pleasure to have out here, that when you are having a bad day, she makes you feel better. Another person told me that Judy made her feel that everything was going to be alright, when the employee was having a significant medical issue. I had to laugh once because a card dealer came to me and said I am sorry to hear Judy is no longer working, I said I am too. The card dealer told me that she always went to Judy and knew that if her blood pressure was bad that Judy was going to look at her "like a mother" and the dealer never wanted to do "her wrong."

All these are examples of who Judy was as a paramedic and as a person, and this is the reason I am asking for an honorary lifetime paramedic certification. I want to give something back to Judy that she held so dear. I ask the commission to grant her this certification.

Respectfully,

Thomas C. Fentress
EMS Coordinator
Paramedic Supervisor
Methodist Hospitals

Northlake Campus
600 Grant Street
Gary, Indiana 46402

Midlake Campus
2269 West 25th Avenue
Gary, Indiana 46404

Southlake Campus
8701 Broadway
Merrillville, Indiana 46410

Attachment #4

Indiana Trauma Registry Pre-hospital Data Report

Report for November 2014

This report from the Indiana State Department of Health (ISDH) EMS registry includes 222,435 runs from 142 pre-hospital providers during the time frame from November 13, 2013 through November 12, 2014. This report also focuses on several sub-populations in this time frame:

1. 55,565 chest pain incidents where chest pain was the complaint reported by dispatch or the provider's primary or secondary impression was chest pain/ discomfort.
2. 20,830 incidents where the 12 lead ECG procedure was performed.

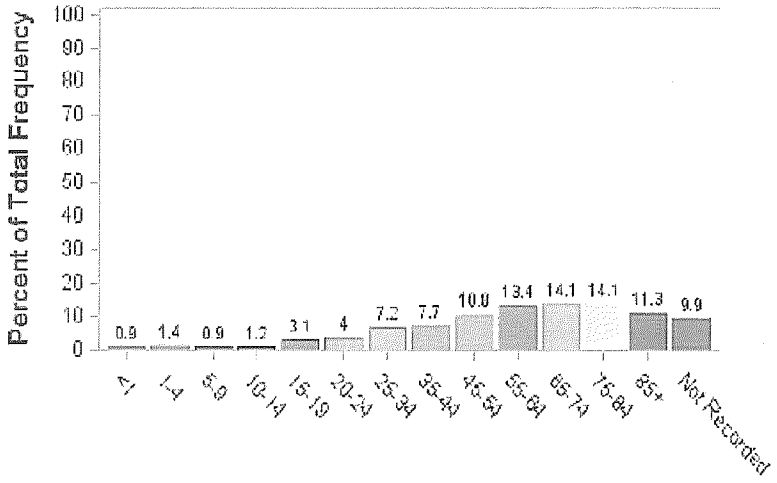
Lastly, 21,278 incidents were reported to the ISDH Indiana Trauma Registry from the same time period (November 13, 2013 through November 12, 2014) and were included to provide data on the injury severity score (ISS) by public health preparedness district.

At a previous EMS Commission meeting, it was requested that prior aid data be provided, specifically to know if aspirin (ASA) was given before the EMS arrived on the scene in cases of chest pain. Additionally, it was requested that medical history of aspirin allergy be provided for incidents of chest pain. Approximately 0.70% of chest pain cases were reported to have allergies to aspirin (46 cases). Please note that the medication allergies data element is a National Emergency Medical Services Information System (NEMSIS) gold element which is not required by either the Indiana Department of Homeland Security (IDHS) or ISDH Pre-hospital registries.

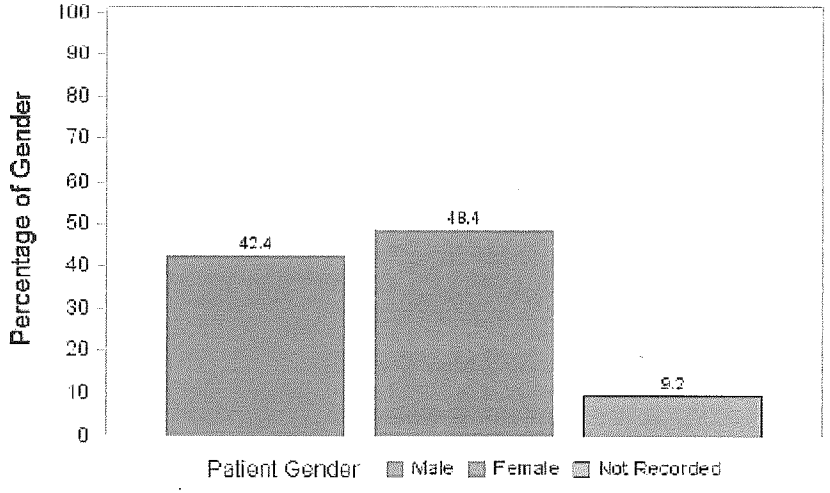
Indiana State
Department of Health

Indiana Trauma Registry Pre-Hospital Data Report
November 13, 2013—November 12, 2014
142 Total Providers Reporting 222,435 Incidents

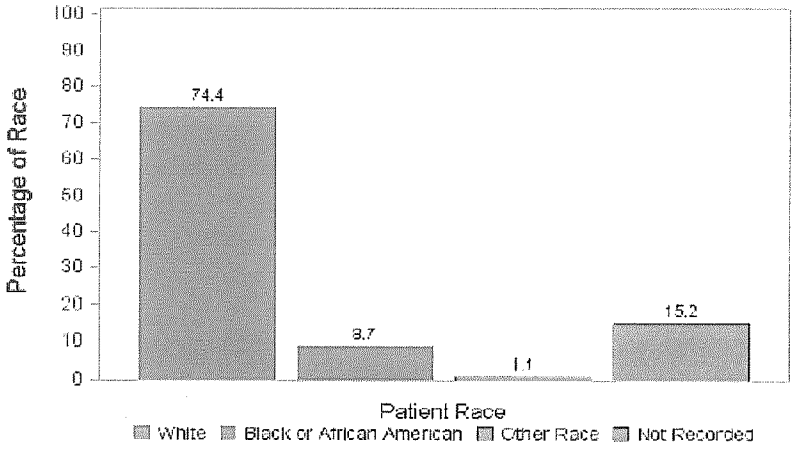
Patient Age



Patient Gender

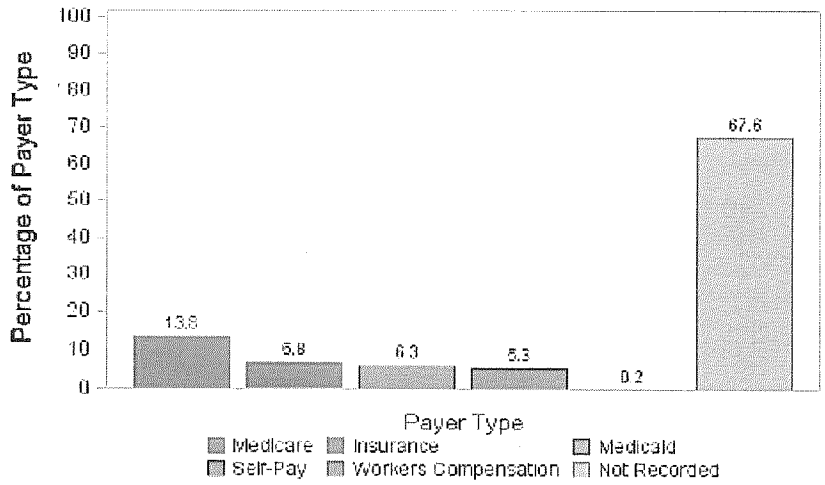


Patient Race



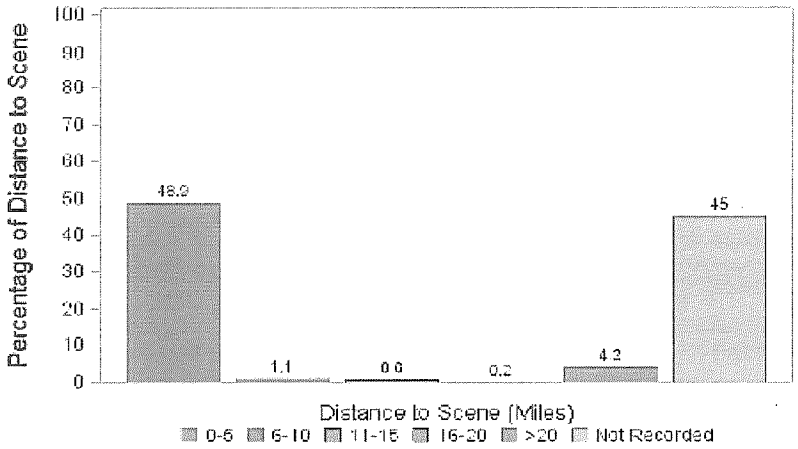
<1% Race: Asian, Native Hawaiian, American Indian/Alaskan Native

Payer Type

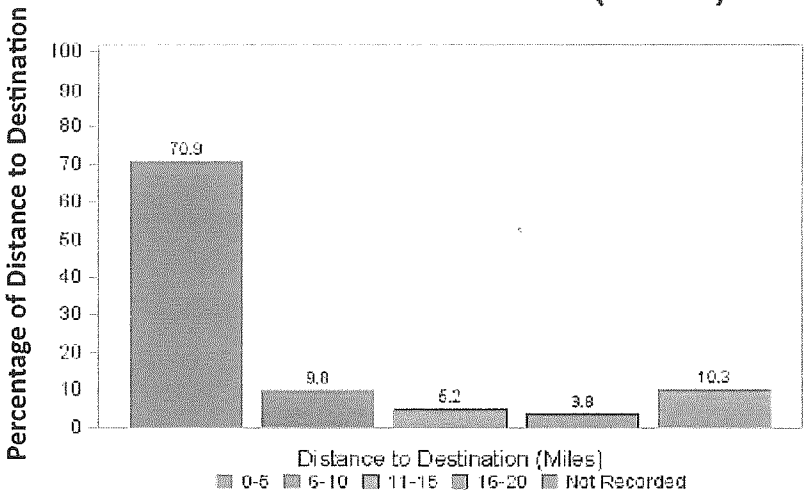


Indiana Trauma Registry Pre-Hospital Data Report
November 13, 2013—November 12, 2014
142 Total Providers Reporting 222,435 Incidents

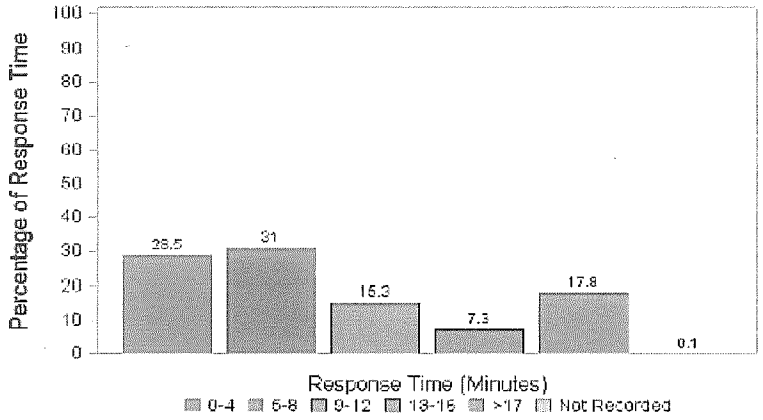
Distance to Scene (Miles)



Distance to Destination (Miles)

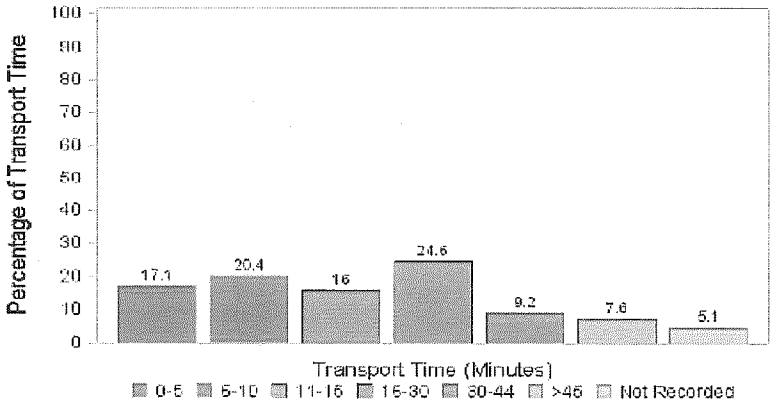


Response Time (Minutes)



Response Time: Difference in Time from Dispatch to Arrival on Scene

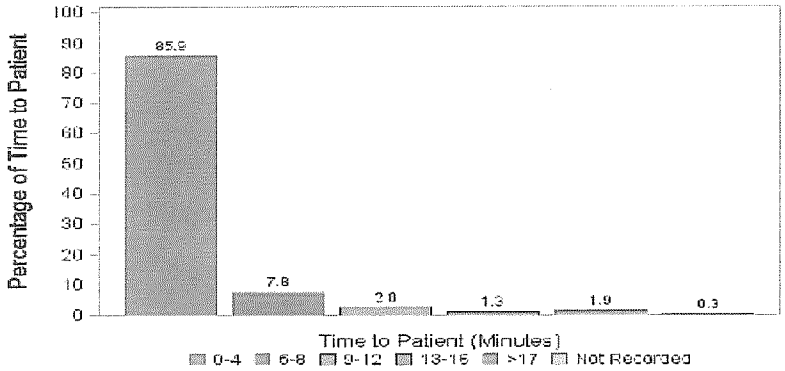
Transport Time (Minutes)



Transport Time: Difference in Time from Departure from Scene to Arrival At Destination

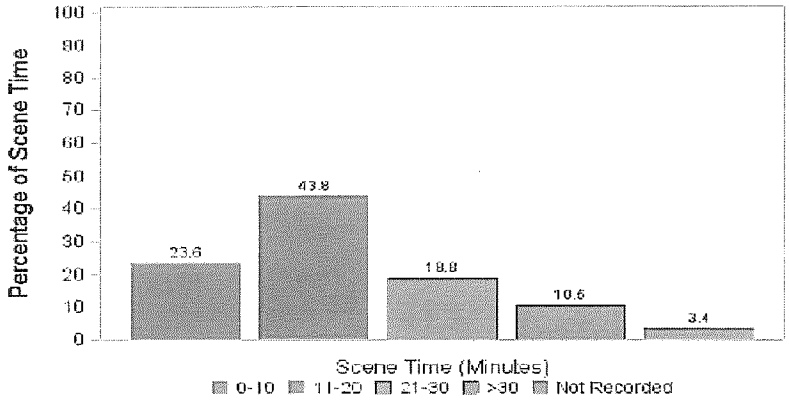
Indiana Trauma Registry Pre-Hospital Data Report
November 13, 2013—November 12, 2014
142 Total Providers Reporting 222,435 Incidents

Time to Patient (Minutes)



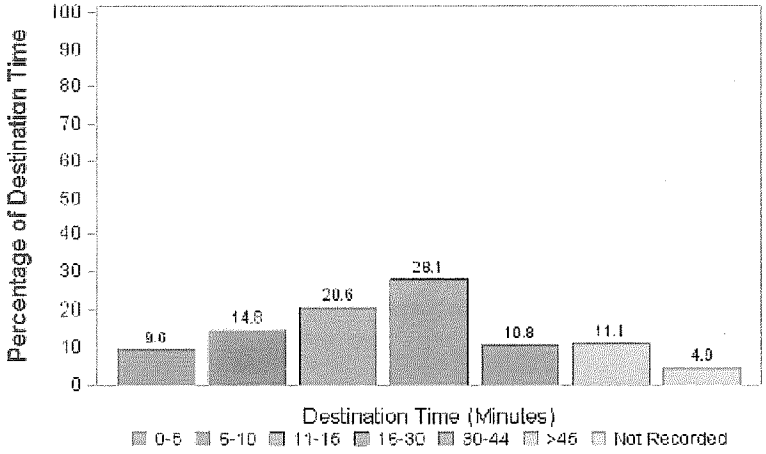
Time To Patient: Difference in Time from Arrival at Scene to Patient Arrival

Scene Time (Minutes)



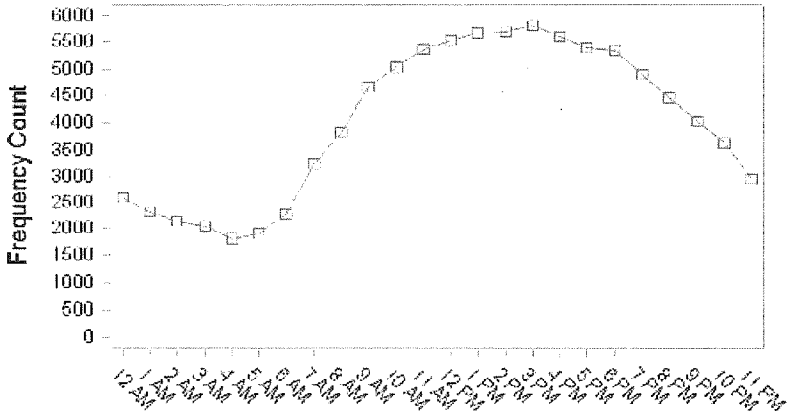
Scene Time: Difference in Time from Arrival at Scene to Leaving Scene

Destination Time (Minutes)



Scene Time: Difference in Time from Arrival at Destination to Unit Back in Service

Time of Call



Time of Call Not Recorded for 126,187 Incidents

Indiana Trauma Registry Pre-Hospital Data Report
November 13, 2013—November 12, 2014
142 Total Providers Reporting 222,435 Incidents

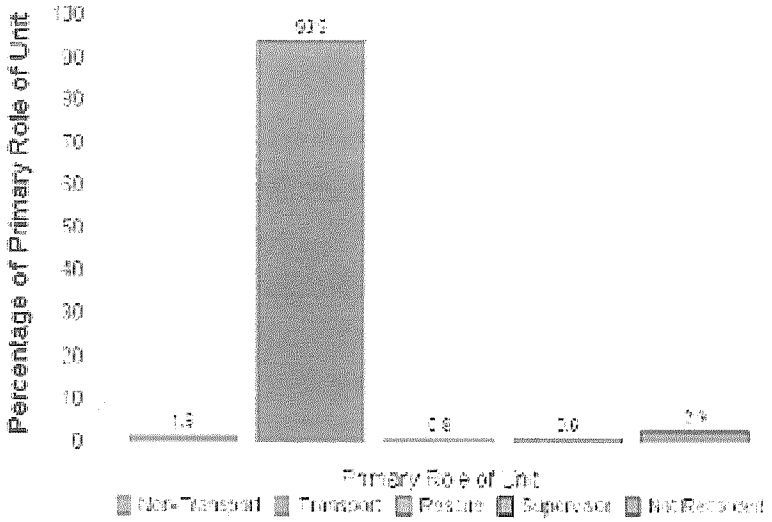
Average Run Mileage

Obs	Destination Miles	
1	Mileage to Scene	4.0
2	Mileage to Destination	3.5
3	Mileage to Ending	1.8
	Total Mileage	9.3

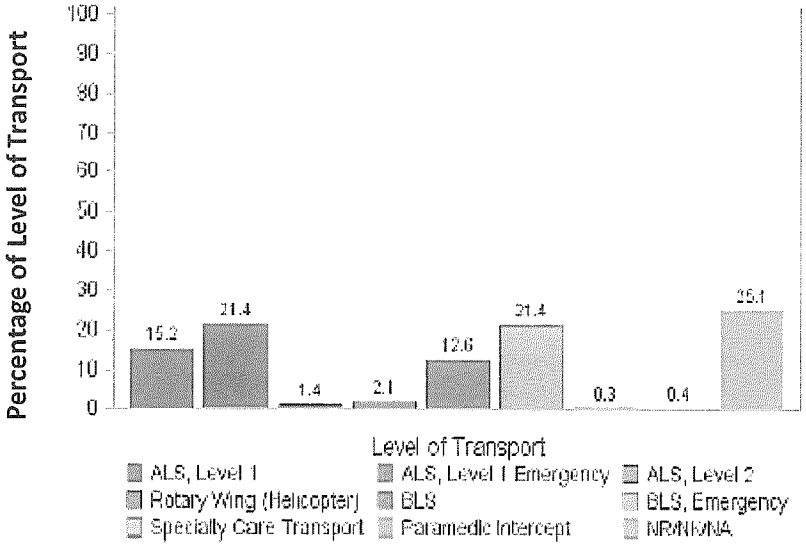
Average Run Time

Obs	Destination Minutes	
1	Time to Scene	11.49
2	Time to Patient	2.70
3	Time at Scene	18.19
4	Time to Destination	18.67
5	Back in Service	22.93
6	Total Run Time	68.30

Primary Role of Unit

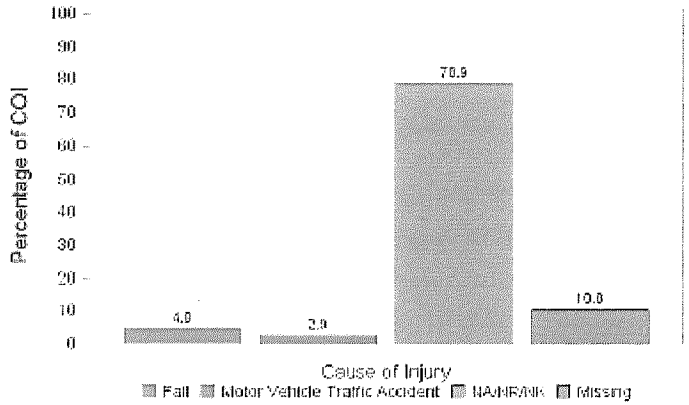


Level of Transport



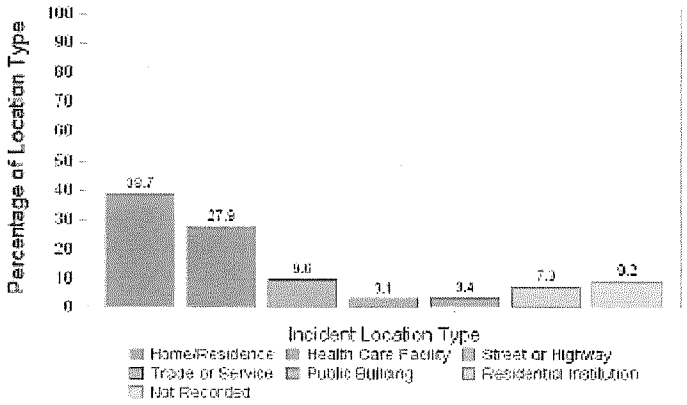
Indiana Trauma Registry Pre-Hospital Data Report
November 13, 2013—November 12, 2014
142 Total Providers Reporting 222,435 Incidents

Cause of Injury (COI)



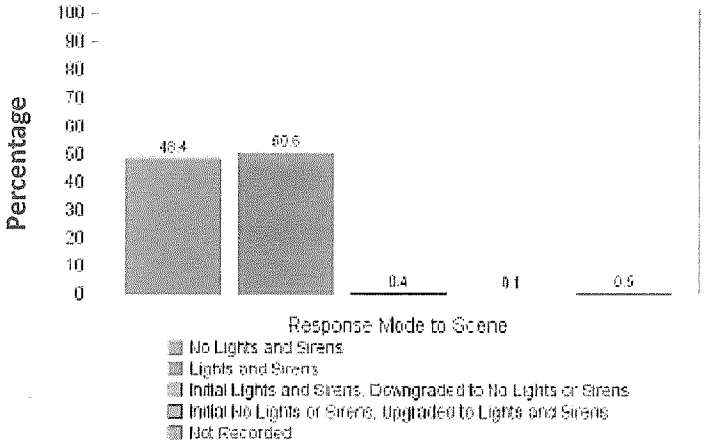
Causes of Injury <1.5% not listed (40 variables)
Bites, Machinery Accidents, Fire/Flames, Pedestrian Traffic

Incident Location Type

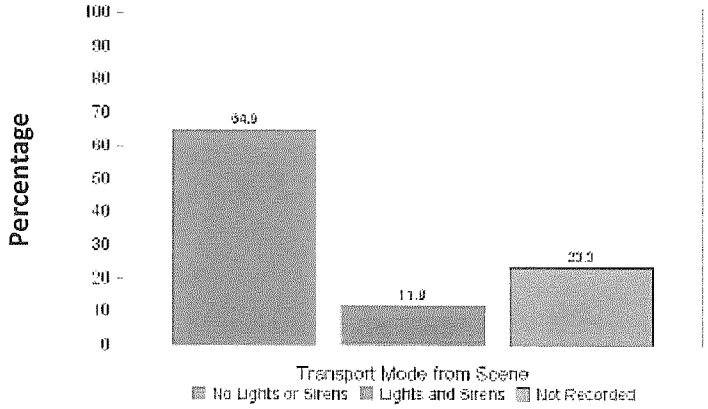


Incident Location Type <1% not listed (4 variables)
Recreation, Farm, Mine, Lake

Response Mode to Scene



Transport Mode from Scene



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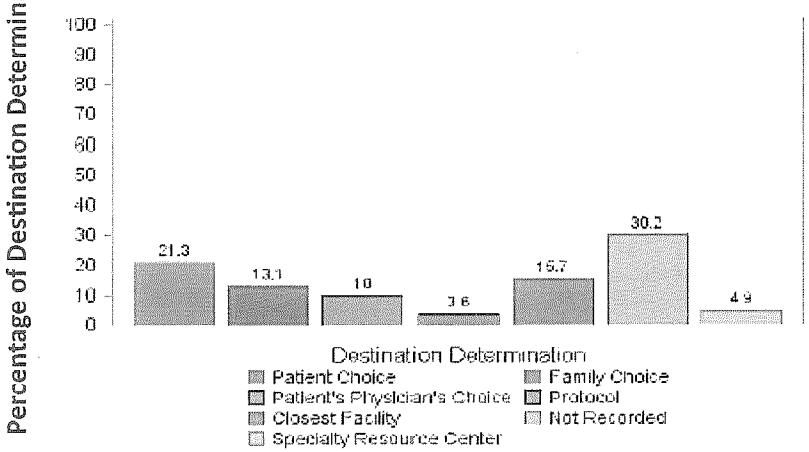
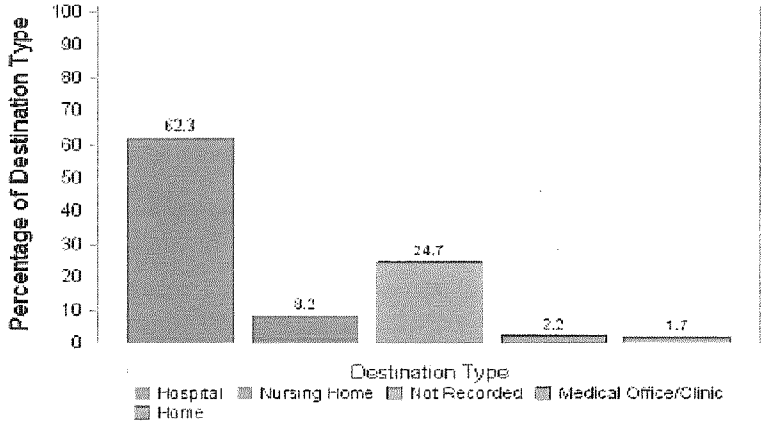
Destination Determination



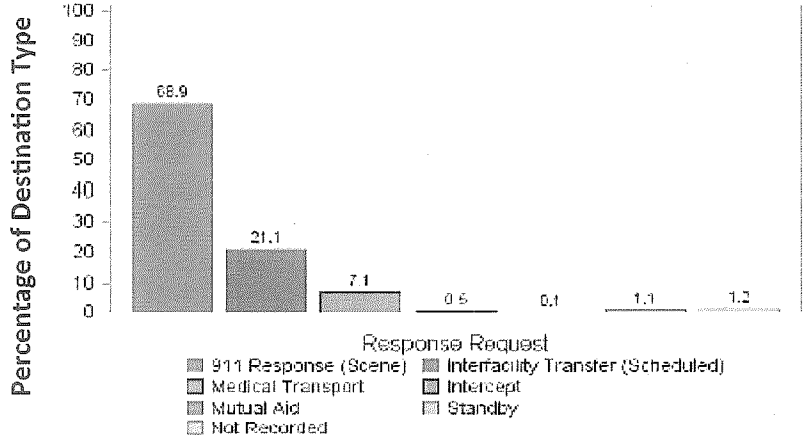
Destination Determinations <1% Not Listed (5 Variables)

Destination Type

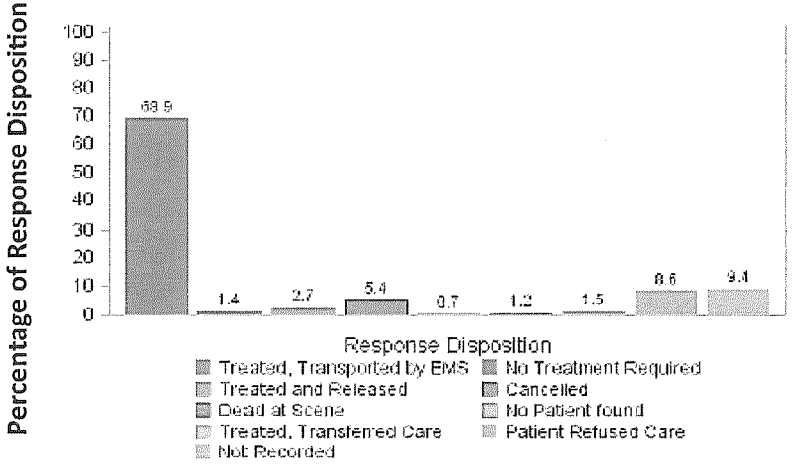


<1% Destination Type:EMS Responder (Ground),Other Morgue, Other EMS Responder (Air), Police/Jail

Response Request



Response Disposition



Indiana Trauma Registry Pre-Hospital Data Report
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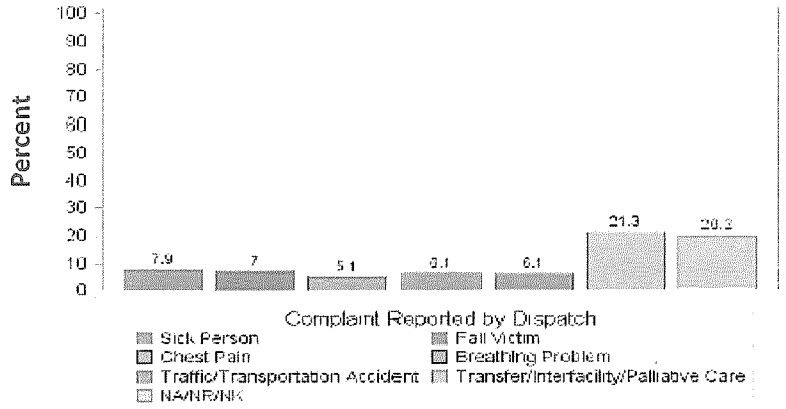
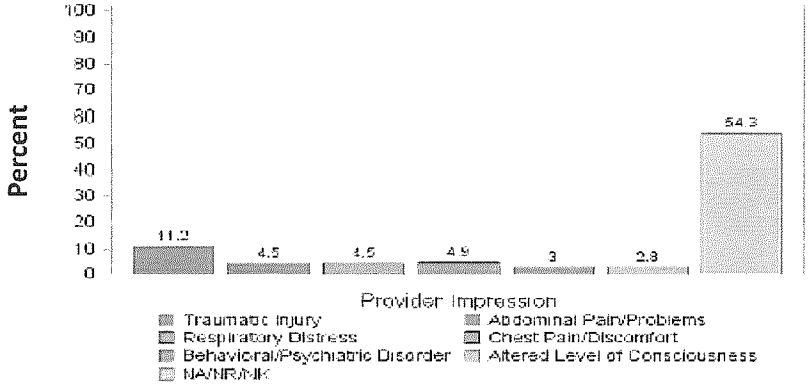
Complaint Reported by Dispatch



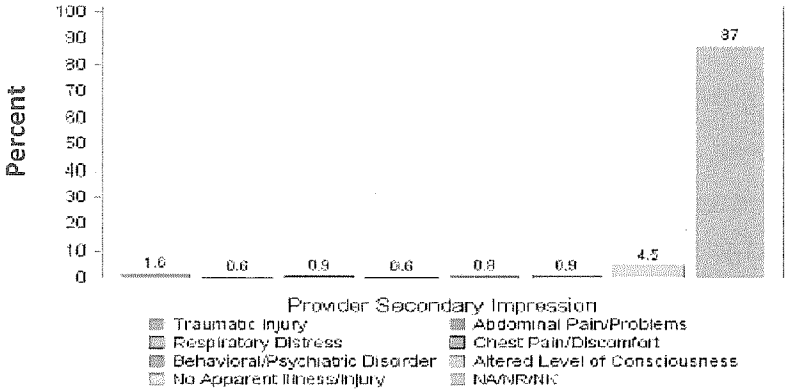
Complaints <3.0% not listed (42 variables)

Provider Primary Impression



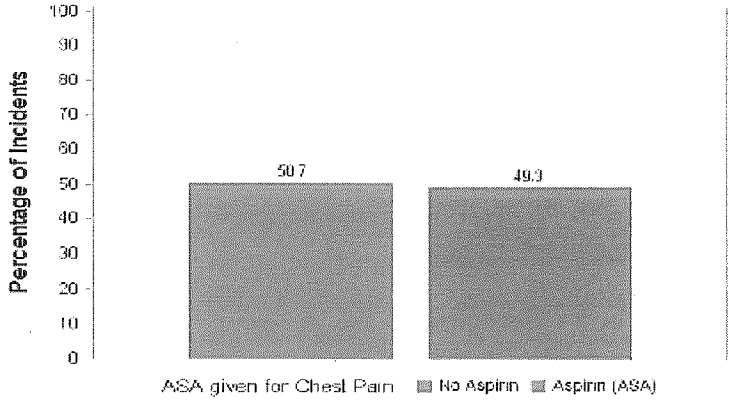
Primary Impressions <2.5% not listed, 27 variables

Provider Secondary Impression



<0.5% P.I.: Pain, Seizure, Other, Stroke/CVA, Syncope/Fainting, Poisoning/Drug

Chest Pain Incidents where ASA Given



Chest Pain Incidents where ASA was Given (2013-YTD)
Chest Pain as complaint reported by dispatch or
the provider's primary or secondary impression; N= 55,565

Indiana Trauma Registry Pre-Hospital Data Report
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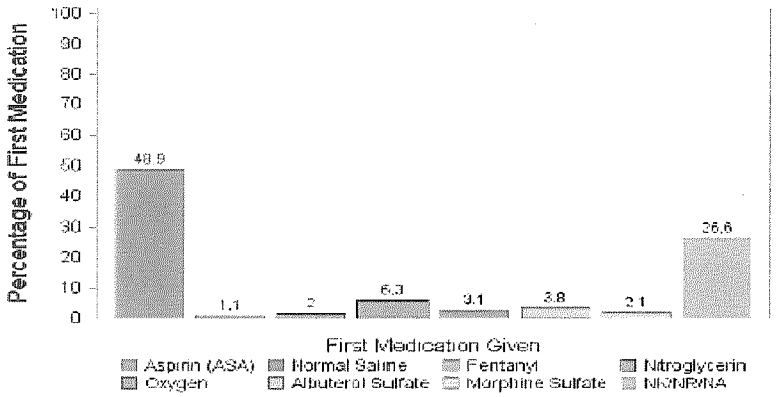
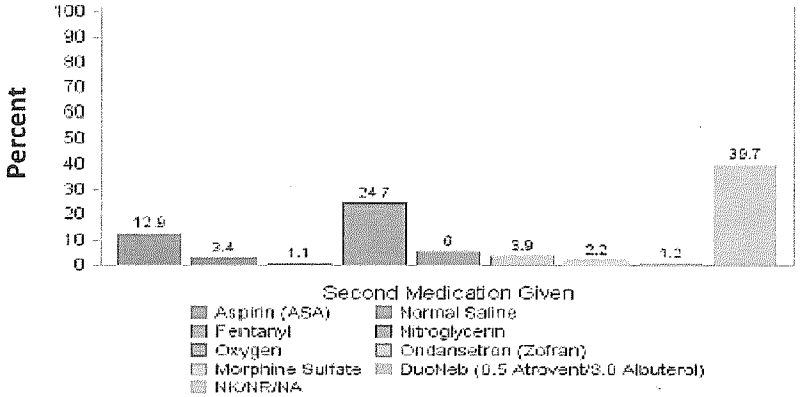
142 Total Providers Reporting 222,435 Incidents

First Medication Given for Chest Pain



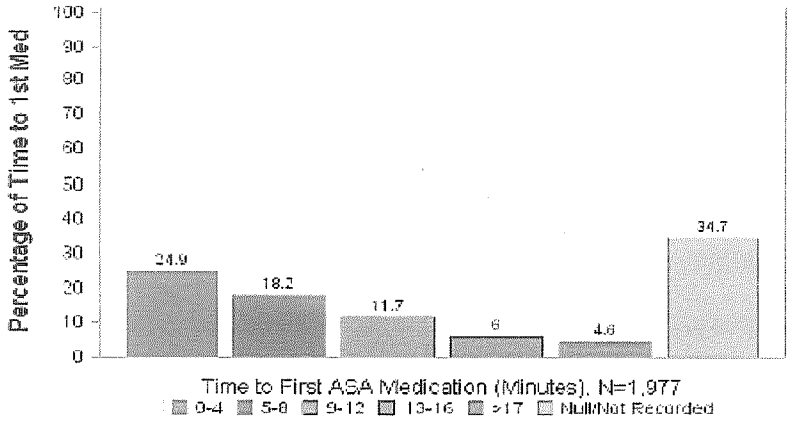
First Medications <0.5% not listed (39 variables)

Second Medication Given for Chest Pain



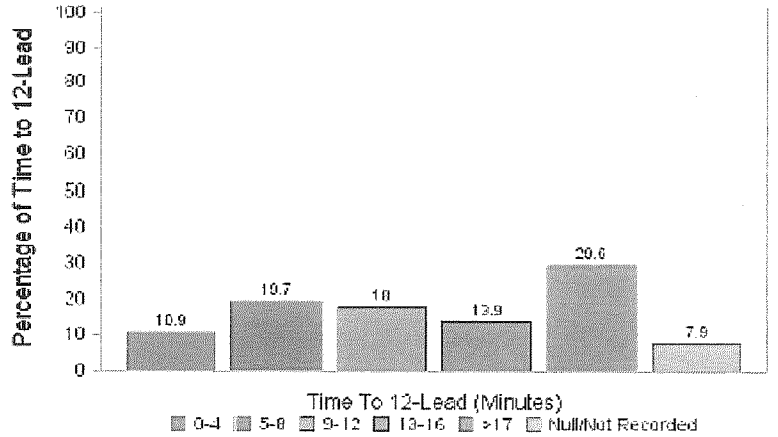
Second Medications <1% not listed (51 variables)

Time to First ASA Medication (Minutes)



Time to 1st Med: Time from Arrived at Patient to First Medication (Aspirin[ASA]) Administered for Chest Pain

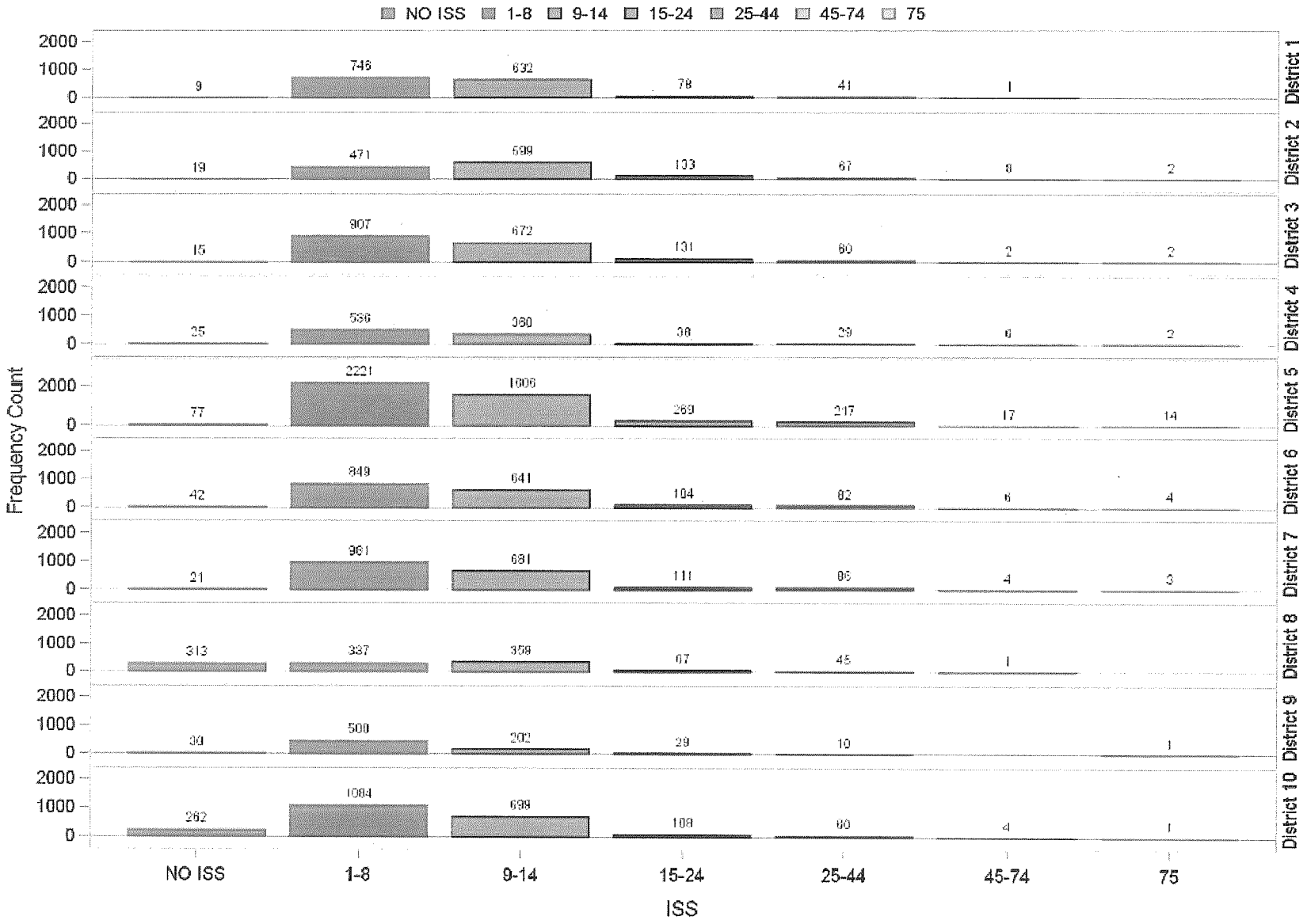
Time to 12-Lead (Minutes)



Time to 12-Lead: Time from Arrived at Patient to Time 12 lead ECG Procedure Performed; N=20,830

Indiana Trauma Registry November 13, 2013—November 12, 2014 21,278 Incidents

Injury Severity Score By Public Health Preparedness Districts



Attachment #5

Indiana Department of Homeland Security

Application for "in the process" Level III Trauma Center status

Hospitals that wish to apply for status as an "in the process" Level III Trauma Center must provide sufficient documentation for the Indiana State Department of Health and the Indiana Department of Homeland Security to conclude that your hospital complies with each of the following requirements:

1. **A Trauma Medical Director** who is Board-Certified, or eligible for board certification, or an American College of Surgeons Fellow. This is a general surgeon who participates in trauma call and is current in Advanced Trauma Life Support (ATLS). The Medical Director must be dedicated to one hospital. The Medical Director must be appointed 6 months before the "in the process" application can be submitted.
    a. **Documentation required:**
        i. Current ATLS certificate. Physician must have successfully completed course prior to application.
        ii. Trauma Medical Director's full CV.
        iii. Guideline/policy/contract that states Medical Director is dedicated to only one facility.
        iv. Copy of past 3 months call rosters documenting Trauma Medical Director's activity on call panel.
        v. Copy of board certification, ACS Fellow status, or eligible for board certification documentation for Trauma Medical Director.
        vi. Documentation of attendance to at least three trauma operation meetings. Meetings must be at least one month apart.
        vii. Documentation of attendance to at least three peer review meetings. Meetings must be at least one month apart.
        viii. 16 hours of external, trauma-related CME's obtained in the 12 months prior to submission of the application.

2. **A Trauma Program Manager**. This person is usually a registered nurse and must show evidence of educational preparation, with a minimum of 16 hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients.
    a. **Documentation required**:
        i. Trauma Program Manager CV.
        ii. Trauma-related continuing education information from the past 12 months in a spreadsheet format.
        iii. Documentation of attendance to at least three trauma operation meetings. Meetings must be at least one month apart.
        iv. Documentation of attendance to at least three peer review meetings. Meetings must be at least one month apart.

3. **Submission of trauma data to the State Registry**. The hospital must be submitting data to the Indiana Trauma Registry following the Registry's data dictionary data standard for the last two quarters prior to submitting the application and at least quarterly thereafter.
    a. **Documentation required**:
        i. The State Trauma Registrar will validate your participation in the Indiana Trauma Registry as required.

4. **A Trauma Registrar**. This is someone who abstracts high-quality data into the hospital's trauma registry and works directly with the hospital's trauma team. This position is managed by the Trauma Program Manager.
    a. **Documentation required**:
        i. Trauma Registrar CV.
        ii. Trauma Registrar job description.
        iii. Proof of trauma registry training (i.e. may include ISDH training or vendor training).

5. **Tiered Activation System**. There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program. Should be inclusive of ACS criteria. Trauma Program Manager, Trauma Medical Director and Emergency Department (ED) liaison must attend Rural Trauma Team Development Course (RTTDC) prior to submission of in process application.
    a. **Documentation required:**
        i. Activation guideline/policy.
        ii. Proof of completion for Trauma Medical Director, Trauma Program Manager and ED liaison at RTTDC.

6. **Trauma Surgeon response times.** Evidence must be submitted that response times for the Trauma Surgeon are as defined by the Optimal Resources document of the American College of Surgeons. Also, there must be a written letter of commitment, signed by the Trauma Medical Director, that is included as part of the hospital's application. There must be evidence that a trauma surgeon is a member of the hospital's disaster committee. All trauma surgeons on the call panel must have successfully completed ATLS at least once.
    a. **Documentation required:**
        i. Individual written statements of support of the trauma program from all participating trauma surgeons, orthopedic surgeons, and neurosurgeons on the call panel, including signature by Trauma Medical Director.
        ii. Complete Surgeon Response Time spreadsheet provided by ISDH Designation Subcommittee.
        iii. Letter from Disaster Committee Chairperson validating a trauma surgeons participation and include record of attendance from past year.
        iv. Copies of past three months general surgery call coverage to show proof of continuous coverage.
        v. Copies of ATLS cards for each general surgeon on the call schedule.
        vi. Copies board certification status for each general surgeon on the call schedule.

7. **In-house Emergency Department physician coverage**. The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients. All ED physicians must have successfully completed ATLS at least once. Physicians who are not board-certified in emergency medicine who work in the ED must be current in ATLS.
    a. **Documentation required:**
        i. Copies of past three months emergency medicine physician call roster, include names of providers if initials are used on call calendar.
        ii. Complete ED physician spreadsheet provided by the ISDH Designation Subcommittee.
        iii. ED liaison CV.
        iv. Copies of ATLS cards for each ED physician.

8. **Orthopedic Surgery**. There must be an orthopedic surgeon on call and promptly available 24 hours per day. There must also be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, for this requirement.
    a. **Documentation required**:
        i. Copies of past three months orthopedic physician call roster, include names of providers if initials are used on call calendar.
        ii. Provide written letter of commitment from orthopedic physicians including signature from all participating orthopedic physicians and Trauma Medical Director.

9. **Neurosurgery**. The hospital must have a plan that determines which type of neurologic injuries should remain at the facility for treatment and which types of injuries should be transferred out for higher levels of care. This plan must be agreed upon by the neurosurgical surgeon and the facility's Trauma Medical Director. There must be a transfer agreement in place with Level I or Level II trauma centers for the hospital's neurosurgical patient population. The documentation must include a signed letter of commitment by neurosurgeons and the Trauma Medical Director.
    a. **Documentation required if ALL patients treated via transfer**:
        i. Policy/guideline that establishes that all patients treated via transfer.
        ii. Copies of transfer agreements with Level I and Level II trauma centers where neurosurgery patients will be sent from your facility.
        iii. Signed letter from Trauma Medical Director (?)
    b. Documentation required if certain patients are kept/treated at your facility:
        i. Policy/guideline that establishes your scope of care and criteria for transfers.
        ii. Copies of past three months neurosurgeon physician call rosters, include physician names if initials are used on call calendar.
        iii. Signed statement from OR manager/director and Trauma Medical Director that craniotomy equipment is at your facility if you plan to keep these patients.
        iv. Letter of commitment from neurosurgeons and Trauma Medical Director.
        v. Traumatic Brain Injury policies/guidelines.

10. **Transfer agreements and criteria**. The hospital must include as part of its application a copy of its transfer criteria and copies of its transfer agreements with other hospitals.
    a. **Documentation required**:
        i. Copy of transfer out policy/criteria.
        ii. Copies of transfer agreements with Level I and Level II trauma centers.

11. **Trauma Operating room, staff and equipment**. There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed OR team, essential equipment (including equipment needed for a craniotomy) and anesthesiologist services 24 hours per day. The application must also include a list of essential equipment available to the OR and its staff. Anesthesiologists must be promptly available for emergency operations. The center must have an identified anesthesia liasion for the trauma program.
    a. **Documentation required**:
        i. List of essential equipment as outlined in Resources for Optimal Care of the Injured Patient resource.
        ii. Policy/guideline outlining staffing procedures for emergent trauma procedures (including OR staff and anesthesia).
        iii. Anesthesiology liaison CV.

12. **Critical Care physician coverage.** Physician coverage of the ICU must be available within 30 minutes, with a formal plan in place for emergency. There must be emergency coverage in-house 24 hours per day. Supporting documentation must include a signed letter of commitment and proof of physician coverage 24 hours a day.
    a. **Documentation required:**
        i. Past three months call schedules for critical care coverage and include physician names if initials are used on the call calendar.
        ii. Signed letter of commitment from critical care physician group and Trauma Medical Director.
        iii. Policy/guideline for who manages airway emergencies on the floor.

13. **CT scan and conventional radiography**. There must be 24-hour availability of CT scan and conventional radiography capabilities. There must also be a written letter of commitment from the hospital's Chief of Radiology.
    a. **Documentation required**:
        i. Signed letter of commitment from Chief of Radiology and Trauma Medical Director.

14. **Intensive care unit**. There must be an intensive care unit with patient/nurse ratio not exceeding 2:1 and appropriate resources to resuscitate and monitor injured patients
    a. **Documentation required**:
        i. Scope of care/nursing standards/staffing guidelines for ICU that outlines nurse to patient ratios.
        ii. Equipment list for the ICU.

15. **Blood bank**. A blood bank must be available 24 hours per day with the ability to type and crossmatch blood products, with adequate amounts of packed red blood cells (PRBC) and fresh frozen plasma (FFP) within 15 minutes. All centers must have massive transfusion protocol developed collaboratively between trauma services and the blood bank. All centers should consider having, platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients.
    a. **Documentation required**:
        i. Location of blood bank (in hospital or offsite address).
        ii. Policy/guideline that includes detail of products available and number of each product on site.
        iii. Copy of massive blood transfusion protocol.

16. **Laboratory services**. There must be laboratory services available 24 hours per day. This should include at a minimum blood typing, cross-matching, analyses of blood, urine, and other body fluids, including microsampling when appropriate. There should be capability for coagulation studies, blood gases, and microbiology.
    a. **Documentation required:**
        i. Guideline/policy that outlines what services are available 24/7.

17. **Post-anesthesia care unit**. The post-anesthesia care unit (PACU) must have qualified nurses and necessary equipment 24 hours per day.
    a. Documentation required:
        i. Include a list of available equipment in the PACU.

18. **Relationship with an organ procurement organization (OPO)**. There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO.
    a. **Documentation required**:
        i. Written policy regarding OPO participation in the trauma program and triggers for notifying OPO.

19. **Diversion policy**. The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than 5% of the time in a rolling 12 month period. The hospital's documentation must include a record of the most recent 12 months showing dates and length of time for each time the hospital was on diversion.
    a. **Documentation required**:
        i. Completed detailed diversion information/why facility activated diversion on required spreadsheet provided by ISDH Designation Subcommittee.

20. **Operational process performance improvement committee**. There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year. This meeting must occur at least quarterly.
    a. **Documentation required:**
        i. Signed letter from Trauma Medical Director and Trauma Program Manager outlining committee membership and meeting frequency.
        ii. Complete Operational Attendance spreadsheet provided by ISDH Designation Subcommittee. Include data from most recent 12 months.
        iii. All Trauma Surgeons and all the Liaisons must have attended at least 2 Operational meetings prior to submission of the application, held no more frequently than monthly.
21. **Trauma Peer Morbidity and Mortality Committee.** The trauma program should have established committee membership and set meeting dates prior to application. This meeting must occur at least quarterly.
    a. **Documentation required**:
        i. Signed letter from Trauma Medical Director and Trauma Program Manager outlining committee membership and meeting frequency.
        ii. Complete Peer Attendance spreadsheet provided by ISDH Designation Subcommittee. Include data from most recent 12 months.
        iii. All Trauma Surgeons and all the Liaisons must have attended at least 2 Trauma Peer Review meetings prior to submission of the application, held no more frequently than monthly.

22. **Nurse credentialing requirements**. Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU.
    a. **Documentation required**:
        i. Policy/guideline that outlines credentialing requirements for nurses in the ED and ICU.
        ii. Percentage of nurses that have completed credentialing requirements for both ED and ICU.

23. **Commitment by the governing body and medical staff**. There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within 1 year of this

application and to achieve ACS verification within 2 years of the granting of "in the process" status.. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one year of this application and/or does not achieve ACS verification within 2 years of the granting of "in the process" status that the hospital's "in the process" status will immediately be revoked, become null and void and have no effect whatsoever.

a. **Documentation required**:
    i. Written statement as outlined under requirements that is signed by governing body and medical staff representative.

Additional Information Necessary

Hospital Name and Mailing Address (no PO Box):

_____

_____

_____

Previously known as (if applicable):

_____

Level of "In the Process" status applied for:

Level Three Adult _____ Level One Pediatric _____

Level Two Pediatric _____

Hospital's status in applying for ACS verification as a trauma center (including Levels being pursued)

_____

_____

_____

Trauma Medical Director:

NAME: _____

Email: _____

Office Phone: _____ Cell/Pgr #: _____

Trauma Program Manager/Coordinator:

NAME: _____

Email: _____

Office Phone: _____ Cell/Pgr #: _____

ATTESTATION: In signing this application, we are attesting that all information contained herein is accurate and that we and our attesting hospital agrees to be bound by the rules, policies and decisions of the Indiana Emergency Medical Services Commission and the Indiana State Department of Health regarding our status under this program.

Chief Executive Officer Signature	Printed	Date
Trauma Medical Director Signature	Printed	Date
Trauma Program Manager Signature	Printed	Date

Indiana Department of Homeland Security

One Year Progress Report for "in the process" Level III Trauma Center

Hospitals that were granted status as an "in the process" Level III Trauma Center are asked to provide sufficient documentation for the Indiana State Department of Health and the Indiana Department of Homeland Security to demonstrate that your hospital continues to comply with the following requirements:

1. **Trauma Medical Director.** The Trauma Medical Director must maintain an appropriate level of trauma-related extramural continuing medical education (16 hours annually or 48 hours over 3 years)

Has the Trauma Medical Director maintained 16 hours of trauma-related extramural continuing medical education since granted "in process" Level III Trauma Center status? *Provide the Trauma Medical Director's certificates for continuing medical education events since granted "in process" Level III Trauma Center status.*	☐ YES ☐ NO

2. **Submission of trauma data to the State Registry**. The hospital must be submitting data to the Indiana Trauma Registry following the Registry's data dictionary data standard within 30 days prior to application submission to ISDH and at least quarterly thereafter.

Has your hospital submitted trauma data to the State Registry quarterly since granted "in process" Level III Trauma Center status?	☐ YES ☐ NO

3. **Trauma Registrar.** Evidence must be submitted that the trauma registrar has attended two courses within 12 months of being hired.

1. American Trauma Society's Trauma Registrar Course or equivalent provided by state trauma program. AND 2. Association of the Advancement of Automotive Medicine's Injury Scaling Course.	☐ YES ☐ NO ☐ YES ☐ NO

4. **Trauma Surgeon response times.** Evidence must be submitted that response times for the Trauma Surgeon are as defined by the Optimal Resources document of the American College of Surgeons.

Have your Trauma Surgeon's maintained a response time as defined by the Optimal Resources document of the American College of Surgeons since granted "in process" Level III Trauma Center status? *Provide your hospital's Trauma Surgeon response times including number of responses, response times and percentage within the required timeframe per Trauma Surgeon (documentation tool attached).* *Provide your hospital's monthly Trauma Surgeon physician call schedules since granted "in process" Level III Trauma Center status.*	☐ YES ☐ NO

Have the Trauma Surgeons maintained 16 hours of trauma-related ~~extramural~~ continuing medical education since granted "in process" Level III Trauma Center status? *Provide the Trauma Surgeons' certificates for continuing medical education events since granted "in process" Level III Trauma Center status.*	☐ YES ☐ NO

5. **Diversion policy**. The hospital must not be on diversion status more than 5% of the time. The hospital's documentation must include a record for the previous year showing dates and length of time for each time the hospital was on diversion.

Has your hospital maintained a diversion status of less than 5% of the time since granted "in process" Level III Trauma Center status? *Provide your hospital's diversion documentation showing reason for diversion and dates and length of time for each time the hospital was on diversion (documentation tool attached).*	☐ YES ☐ NO

6. **In-house Emergency Department physician coverage.** The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients.

   Neurosurgery, if applicable. The hospital must have a plan that determines which type of neurologic injuries should remain at the facility for treatment and which types of injuries should be transferred out for higher levels of care. If neurologically injured patients are admitted for at your facility, please provide your hospital's Neurosurgery physician call schedules since granted "in process" Level III Trauma Center status.

   Orthopedic Surgery. There must be an orthopedic surgeon on call and promptly available 24 hours per day.

   Critical Care Physician coverage. Physician coverage of the ICU must be available within 30 minutes, with a formal plan in place for emergency. There must be emergency coverage in-house 24 hours per day.

Have your Emergency Department have the appropriate number of physicians to ensure immediate care for injured patients?	Emergency Medicine: ☐ YES ☐ NO
If neurologically injured patients are admitted for at your facility, *please provide your hospital's Neurosurgery physician call schedules since granted "in process" Level III Trauma Center status.*	Neurosurgeons: ☐ YES ☐ NO ☐ N/A
Have your Orthopedic Surgeons and Critical Care Physicians maintained coverage 24 hours per day since granted "in process" Level III Trauma Center status? *Provide your hospital's monthly Emergency Medicine, Orthopedic and Critical Care physician call schedules since granted "in process" Level III Trauma Center status.*	Orthopedic Surgeons: ☐ YES ☐ NO Critical Care Physicians: ☐ YES ☐ NO

7. **Operational process performance improvement committee**. There must be a trauma program operational process performance improvement committee that meets at least quarterly.

Has your Trauma Program Operational Process Performance Committee met at least quarterly since granted "in process" Level III Trauma Center status? *Provide your hospital's committee meeting dates and times along with a roster of the committee members and their attendance (documentation tool attached).*	☐ YES ☐ NO

8. **Trauma Peer Review Committee.** There must be a multidisciplinary peer review committee with participation by the trauma medical director and representatives from General Surgery, Orthopedic Surgery, Neurosurgery, Emergency Medicine, and Anesthesia to improve trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses. This committee must meet at least quarterly.

Has your Trauma Peer Review Committee met at least quarterly since granted "in process" Level III Trauma Center status?	☐ YES ☐ NO
Have the trauma medical director and representatives from General Surgery, Orthopedic Surgery, Neurosurgery, Emergency Medicine, and Anesthesia attended your multidisciplinary peer review committee at least 50% of meetings since granted "in process" Level III Trauma Center status? *Provide your hospital's committee meeting dates and times along with a roster of the committee members and their attendance (documentation tool attached).*	Trauma Medical Director: ☐ YES ☐ NO General Surgeon: ☐ YES ☐ NO Orthopedic Surgeon: ☐ YES ☐ NO Neurosurgeon: ☐ YES ☐ NO Emergency Medicine: ☐ YES ☐ NO Anesthesia: ☐ YES ☐ NO

9. **Trauma Volumes.** Complete the following tables. Do not include DOA's and direct admits.

Injury Severity and Mortality					
ISS	Total Number of Admissions	Number of Deaths from Total Trauma Admissions	Percent Mortality from Trauma Admissions	Number admitted to Trauma Service	Number of Trauma Patients Transferred out
0-9					
10-15					
16-24					
> or/= 25					
Total					

Total # of Trauma Patients Transferred Out	Average Time to Transfer (Arrival to Transfer)	Total # of Trauma Patients transferred after 120 minutes	Total # of Trauma Patients admitted to your facility with an ISS >25
	(min)		

Additional Information Necessary

Hospital Name and Mailing Address (no PO Box):

_____

_____

_____

Previously known as (if applicable):

_____

Date the "In the Process" status was granted:

Level Three Adult _____

Hospital's status in applying for ACS verification as a trauma center (including Levels being pursued and date of scheduled ACS verification visit)

_____

_____

_____

Trauma Medical Director:

NAME: _____

Email: _____

Office Phone: _____ Cell/Pgr #: _____

Trauma Program Manager/Coordinator:

NAME: _____

Email: _____

Office Phone: _____ Cell/Pgr #: _____

ATTESTATION: In signing this application, we are attesting that all information contained herein is accurate and that we and our attesting hospital agrees to be bound by the rules, policies and decisions of the Indiana Emergency Medical Services Commission and the Indiana State Department of Health regarding our status under this program.

Chief Executive Officer Signature	Printed	Date
Trauma Medical Director Signature	Printed	Date
Trauma Program Manager Signature	Printed	Date

Total Number of Trauma Peer Review Committee meetings held last year:

1. Please place total number of Trauma peer Revie
2. Place all meeting dates in columns C2 through M
columns . (i.e. if you only had quarterly meetings,
3. Then list all committee members in column A w
4. The overall attendance will automatically calcul

Trauma Peer Review Committee Member Name	Specialty Represented	Insert Date	Insert Date	Insert Date	Insert Date	Insert Date	Insert Date	Insert Date
Example: John Smith, MD	*Trauma Surgeon*	*X*	*X*		*X*		*X*	

ew Committee meetings held in B1 field.
N2, using only the number of columns appropriate for your facility and deleting excess
then enter dates in C2 through F2)
ith their attendance recorded in appropriate columns.
ate in column O and overall percentage in column P.

Insert Date	Insert Date	Insert Date	Insert Date	Insert Date	Overall Attendance	Overall Attendance Percentage
X		X		X	7	#DIV/0!
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					0	
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Attachment #6

E. V. E. N. T.
The EMS Voluntary Notification Tool

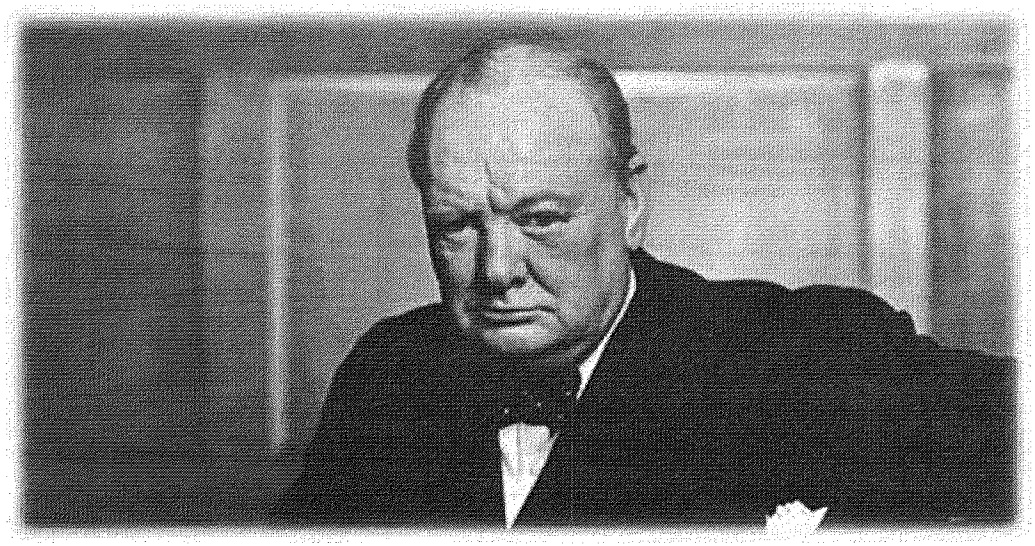
Garrett Hedeen MHA, EMT-P
NAEMT Health and Safety Committee

E.V.E.N.T.
EMS Voluntary Event Notification Tool
An EMS Culture of Safety Initiative

NAEMT
Serving our nation's EMS practitioners.

"Personally I'm always ready to learn, although I do not always like being taught."

Winston Churchill



Primum Non Nocere!

* 44,000-98,000 die each year from preventable medical errors

IOM Recommendations

The IOM's Four-Part Message

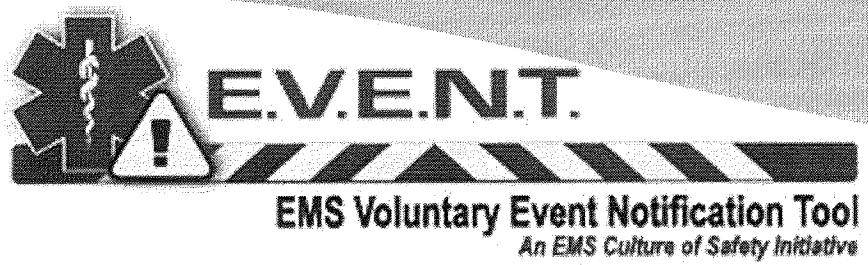
Part 1: National Center for Patient Safety

Part 2: **Mandatory and Voluntary Reporting Systems**

Part 3: Role of Consumers, Professionals, and Accreditation Groups

Part 4: Building a Culture of Safety

EVENT Reporting Tool

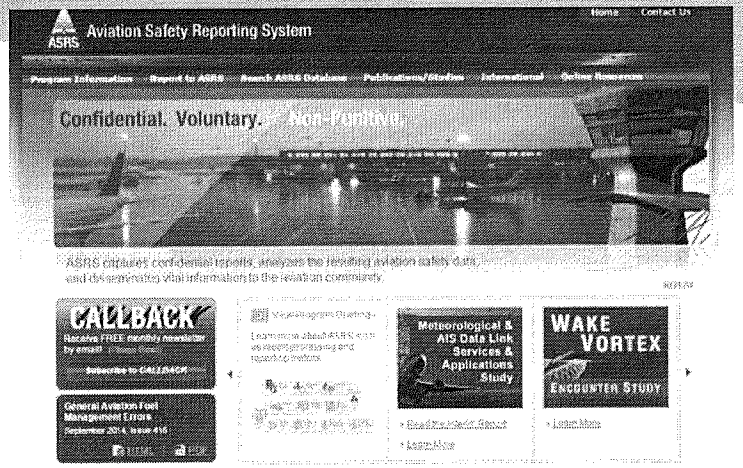


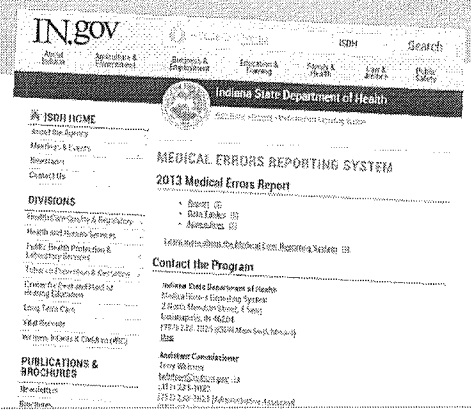
Event.clirems.org

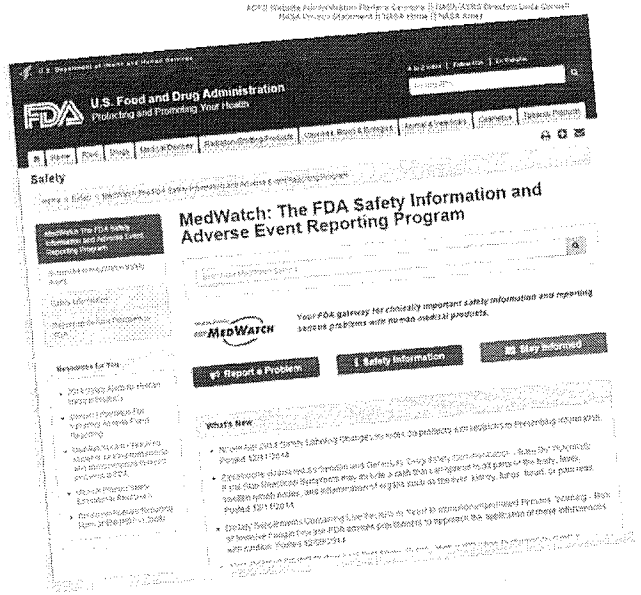
E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services.

It collects data submitted anonymously by EMS practitioners. The data collected will be used to develop policies, procedures and training programs to improve the safe delivery of EMS.

Other Voluntary Reporting Systems





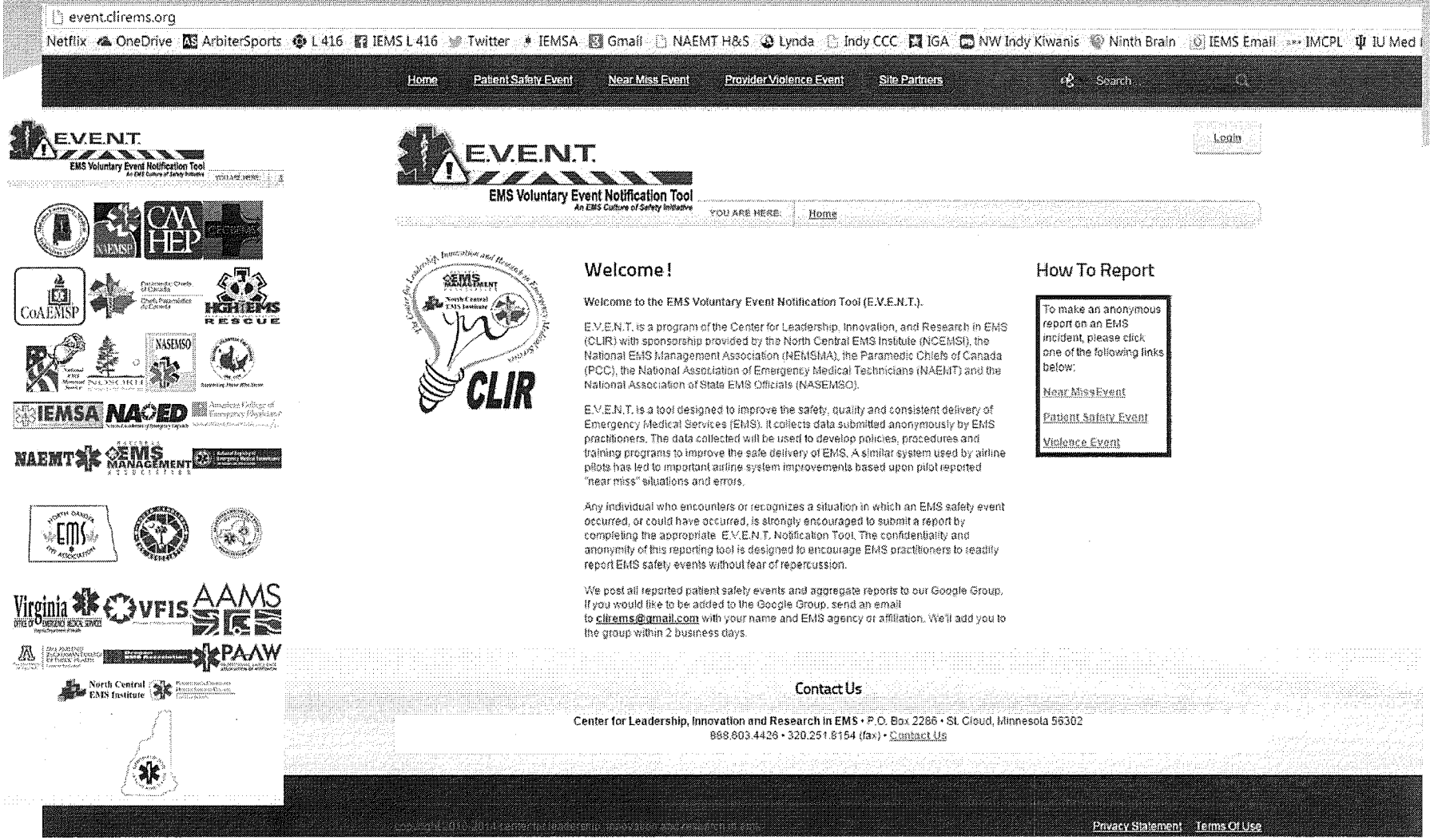


SHARE

LEARN

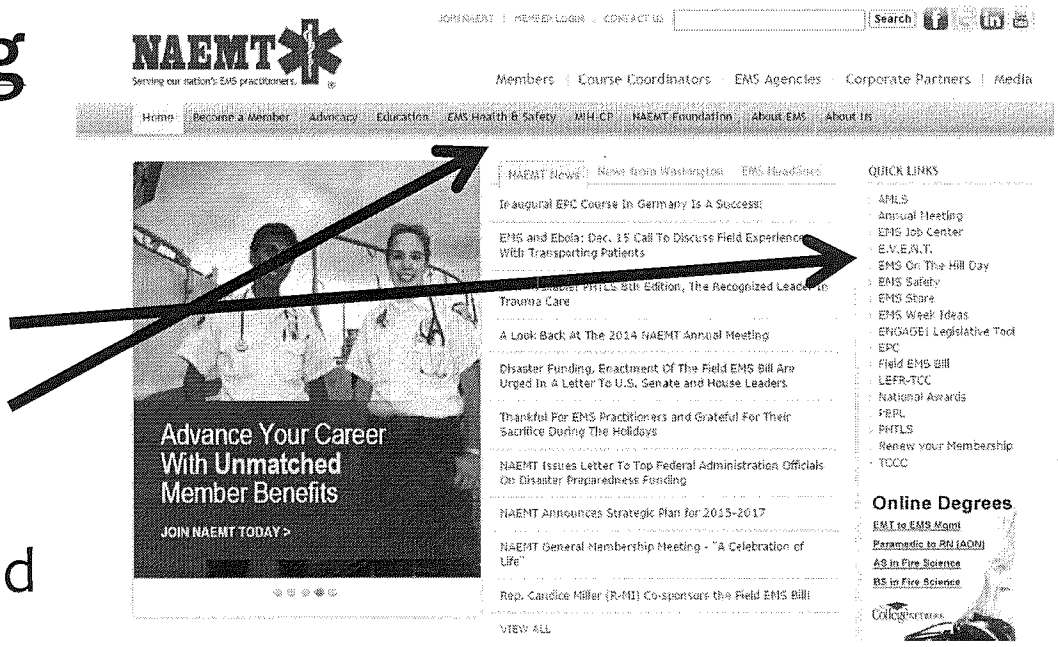
TRAIN

EVENT Reporting Tool

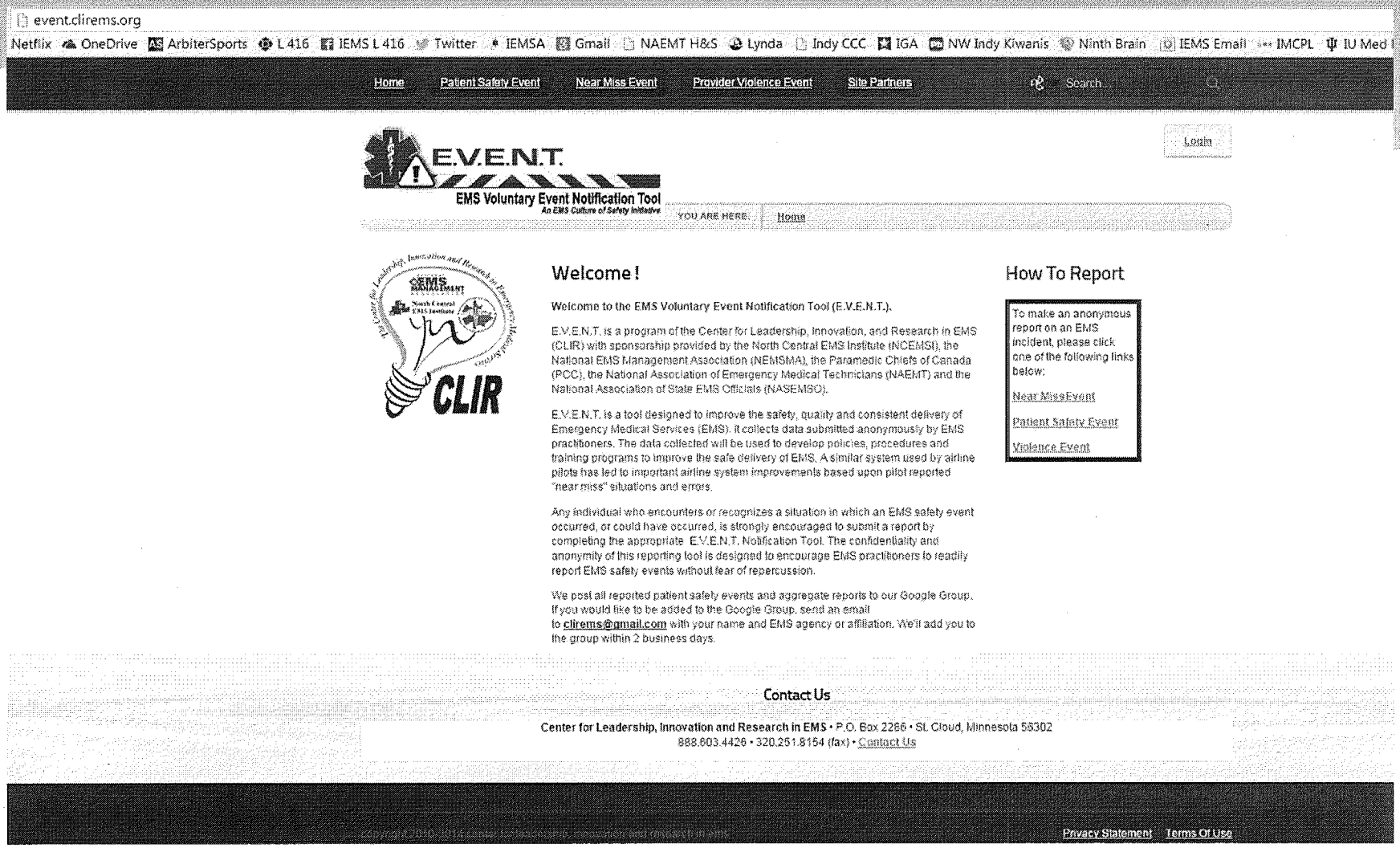


How to Access

* **Event.clirems.org**
* Search *EMS Event Reporting*
* NAEMT
  * Health and Safety Resources
* Other organizations and associations

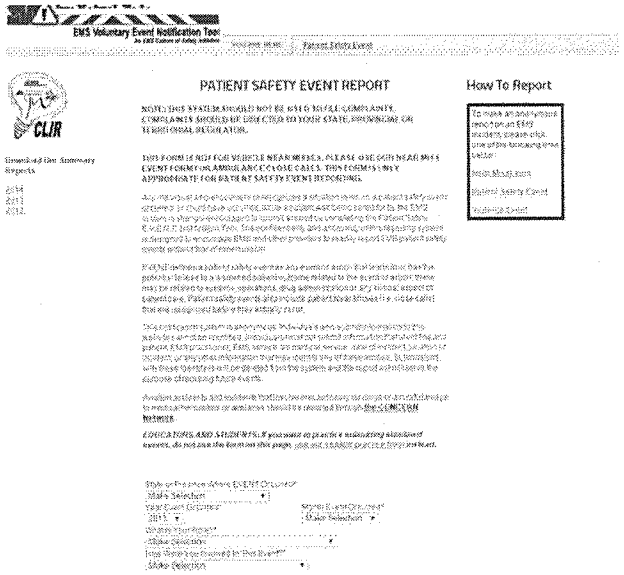


EVENT Reporting Tool



Patient Safety Event

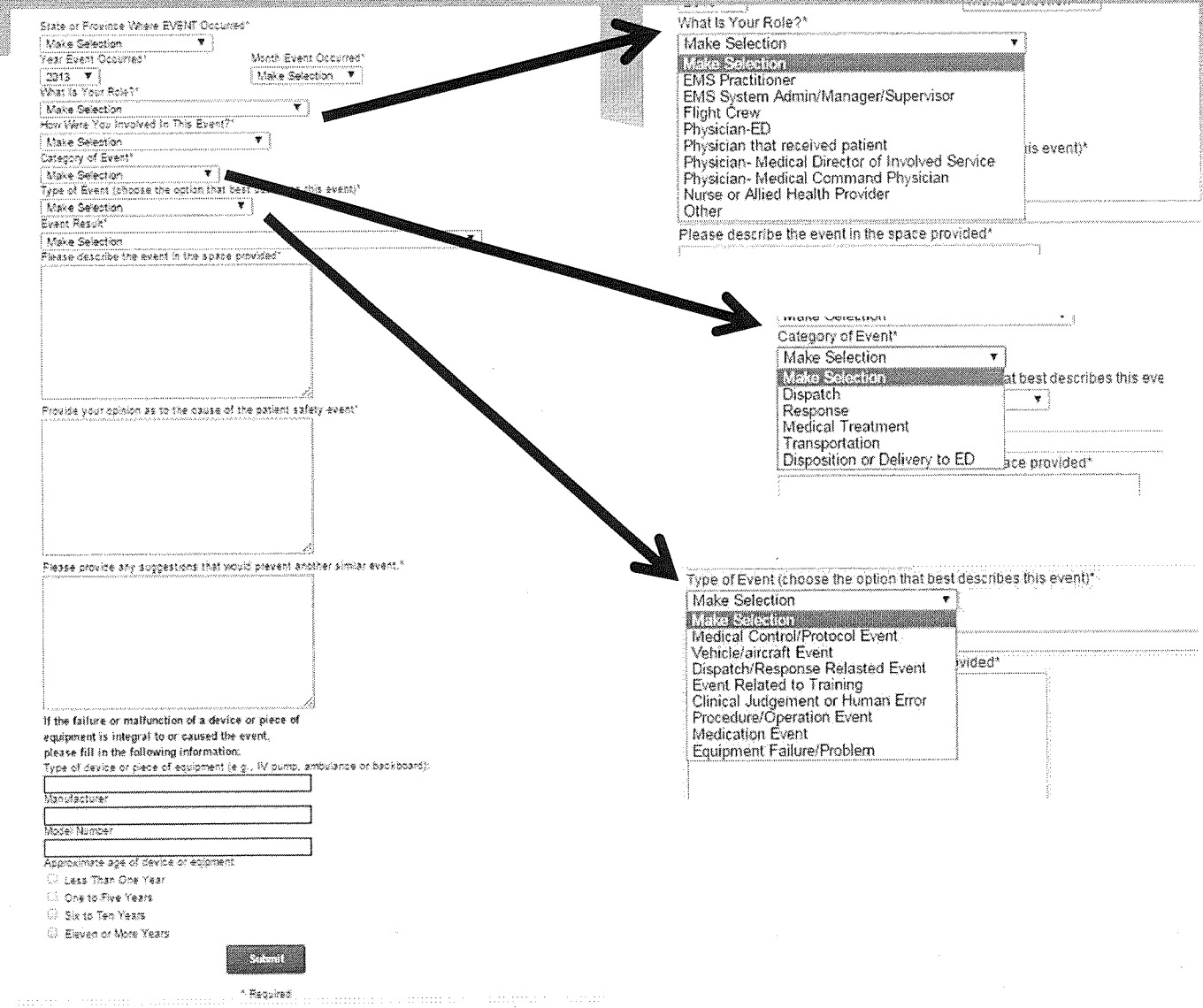
* Any event or action that leads to or has the potential to lead to a worsened patient outcome related to the event or action: these may be related to systems, operations, drug administration or any clinical aspect of patient care.
* Patient safety events also include patient Near Misses (i.e. close calls) that are recognized before they actually occur.


EMS Voluntary Event Notification Tool

PATIENT SAFETY EVENT REPORT

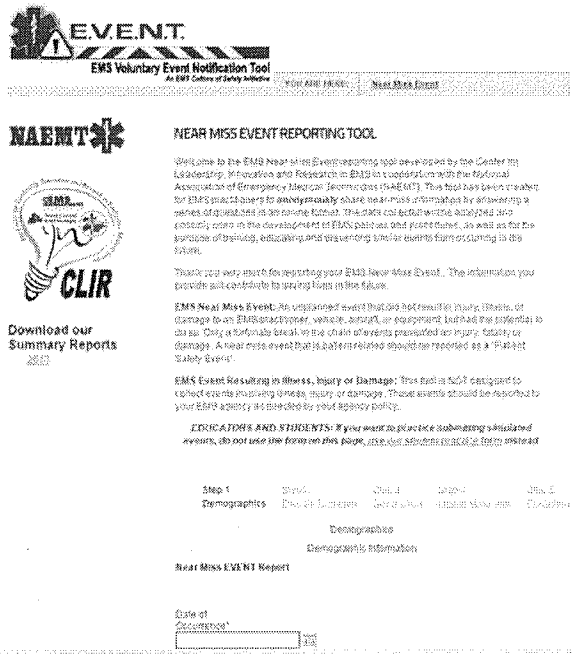
How To Report

Patient Safety Event



Near Miss Event

* An unplanned event that did **NOT** result in injury, illness, or damage to an EMS practitioner, vehicle, aircraft, or equipment, but had the potential to do so.
* *Only a fortunate break in the chain of events prevented an injury, fatality or damage.*
* A near miss event that is patient related should be reported as a "Patient Safety Event".



Near Miss Event

EMS Event Resulting in Illness, Injury or Damage: This tool is NOT designed to collect events involving illness, injury or damage. Those events should be reported to your EMS agency as directed by your agency policy.

EDUCATORS AND STUDENTS: If you want to practice submitting simulated events, do not use the form on this page, use our student practice form instead.

Step 1 Demographics | Step 2 Event Information | Step 3 Description | Step 4 LessonsLearned | Step 5 Practitioner | Step 6 Organization

Demographics

Demographic Information

Near Miss EVENT Report

Date of Occurrence*

Hour of Occurence*
Make Selection

Visibility at time of event*
Make Selection

State or Province Where EVENT Occurred*
Make Selection

Type of service area where Near Miss occurred:*
Make Selection

What was your participation in the event?*
Make Selection

* Required

Start >>

Contact Us

Center for Leadership, Innovation and Research in EMS • P.O. Box 2286 • St. Cloud, Minnesota 56302
888.603.4426 • 320.251.8154 (fax) • Contact Us

Demographics | Event Information | Description | Lessons Learned

Event Information

Near Miss Event Information

Near Miss Event Type (choose two)*
- Make Selection
- Ground Event
- Air Medical Event
- Emergent
- Non-Emergent

Near Miss event occurred:*
Make Selection

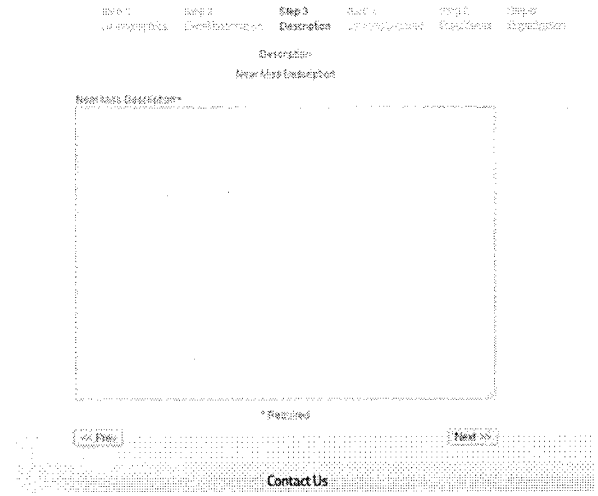
Describe "other" Near Miss event circumstances not included above

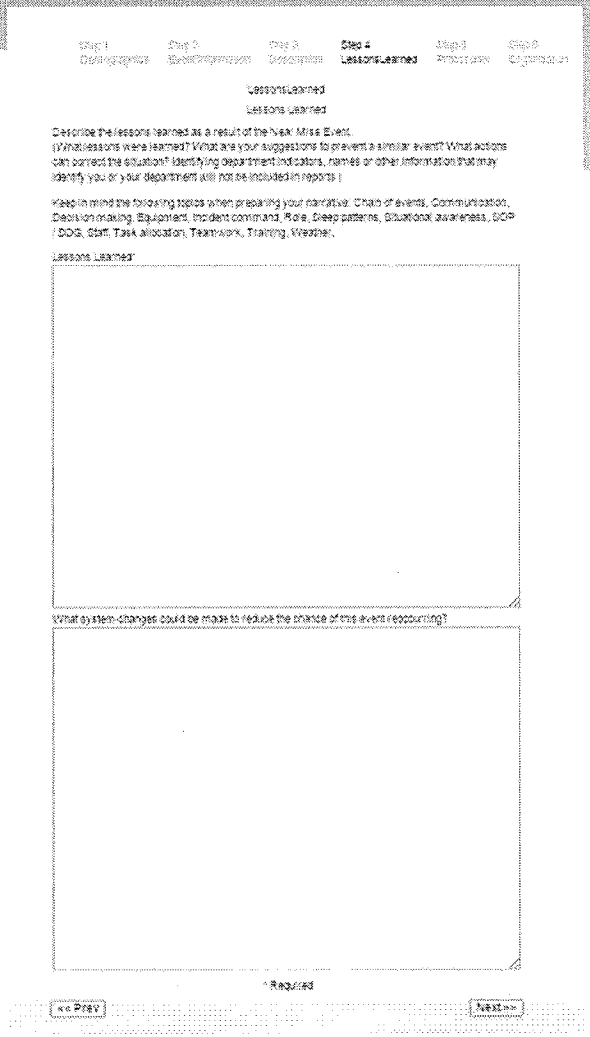
Contributing Factors (select up to 5)*
- Accountability
- Command
- Communication
- Decision Making
- Equipment
- Fatigue
- Distracted driver/pilot (radio, cell phone, other)
- Horseplay
- Human Error
- Individual Action
- Procedure
- Protocol
- Situational Awareness
- SOP / SOG
- Staffing
- Task Allocation
- Teamwork
- Training Issue
- Unknown
- Weather
- Violent patient
- Violent non-patient
- Inadequate fighting
- Other (describe below)

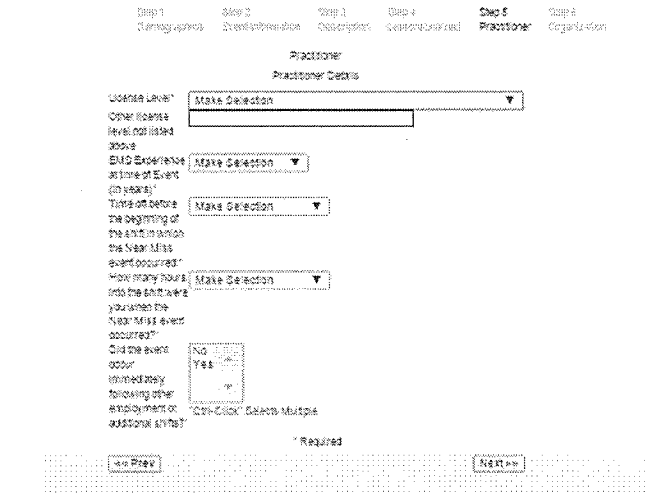
Other contributing factor (please describe)

What prevented injury, illness or damage in this event?

Near Miss Event







Violence Event

EMS Voluntary Event Notification Tool
An EMS Culture of Safety Initiative

YOU ARE HERE: Provider Violence Event

NATIONAL EMS MANAGEMENT ASSOCIATION

CLIR

EMS Provider Violence EVENT Report

Welcome to the Violence Against EMS Provider Reporting Tool developed by the Center for Leadership, Innovation and Research in EMS in cooperation with the National EMS Management Management Association (NEMSMA). This tool has been created for EMS practitioners to **anonymously** share violence against EMS provider information by answering a series of questions in an online format. The data collected will be analyzed and possibly used in the development of EMS policies and procedures, as well as for the purpose of training, educating and preventing similar events from occurring in the future.

Thank you very much for reporting your violence against EMS provider incident. The information you provide will contribute to saving lives in the future.

EDUCATORS AND STUDENTS: If you want to practice submitting simulated events, do not use the form on this page, use our student practice form instead.

Download Summary Reports

2014
2013

Step 1 Location | Step 2 Victim | Step 3 Assailant | Step 4 Other

Location

Demographic and Location Information

Provider Violence EVENT Report

Date of Occurrence* Hour of Occurence*

Make Selection

State or Province Where EVENT Occurred*

Make Selection

City

Place of Assault*

Make Selection

Response Dispatch Priority*

Make Selection

Response Time Range*

Make Selection

Time on Scene*

Make Selection

Practitioner Level*

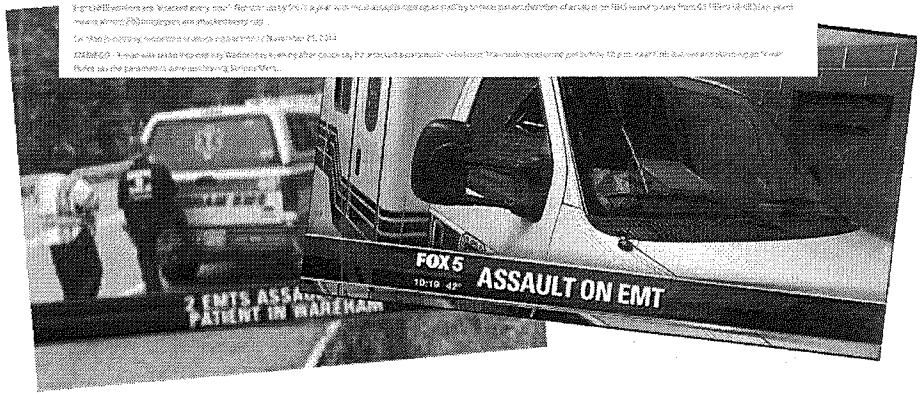
Make Selection

* Required

DT4EMS
Saving Yours While You Save Others

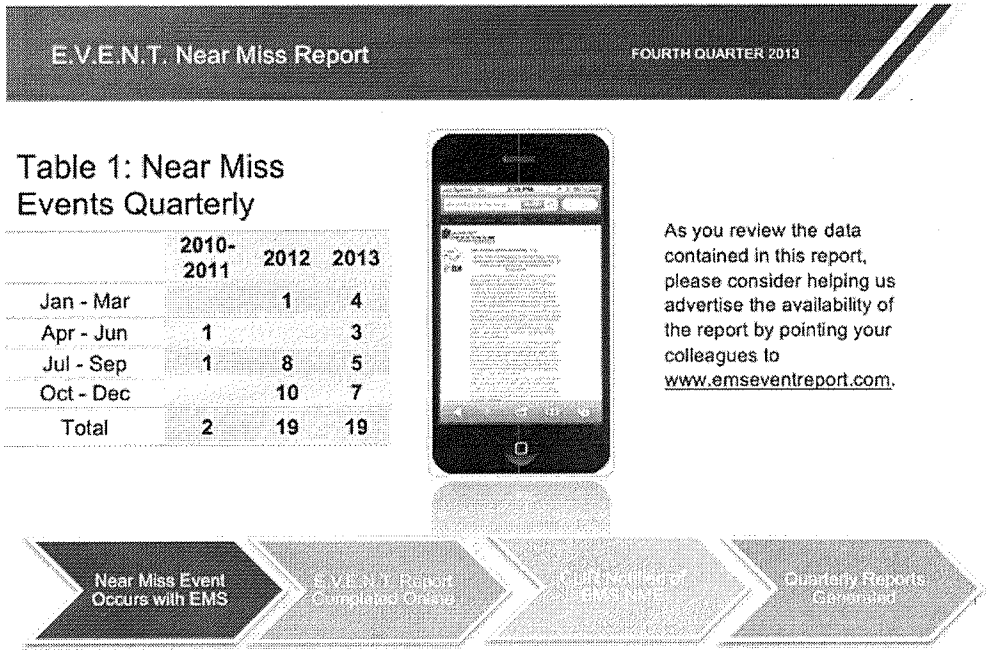
ASSAULT LOG

Active Assault Log



Reports

* Available to the public with individual report identifiers scrubbed



When an anonymous E.V.E.N.T. report is submitted, our team is notified by email. In the United States, the anonymous event report is shared with the state EMS office of the state in which the event was reported to have occurred. The state name in the report is then removed and the record is shared through our Google Group and kept for this summary report. Canadian records have the Province name removed, and then the reports are shared through the Paramedic Chiefs of Canada, and kept for inclusion in aggregate reports.

Reports

Figure 17: Hours into Shift at time of NME

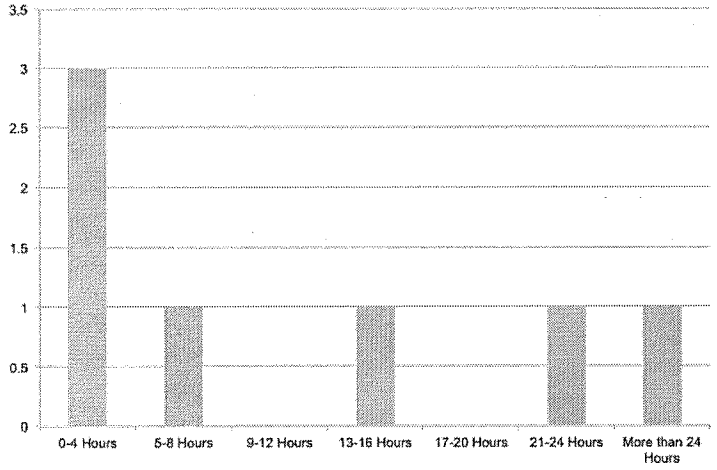
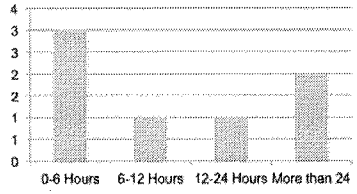
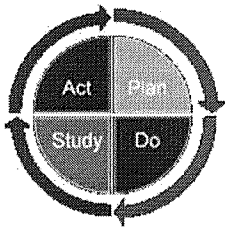


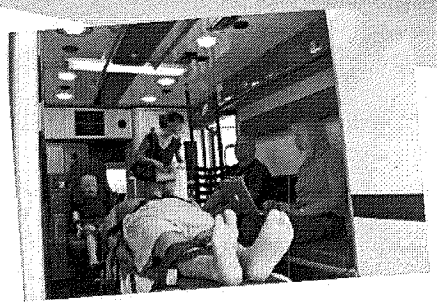
Figure 18: Time off before beginning of shift with NME



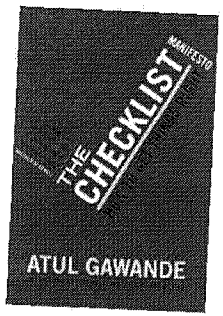
#	Description	Lessons Learned/System Change
1	Two ambulances were backed end to end in a bay. Paramedic was transferring equipment from one truck to the other during restocking phase. Paramedic stepped from one bumper to the other while holding the grab handle on each rear door. Upon contact with the second ambulance, the Paramedic experienced a significant electrical shock. Witness Paramedic reported shock lasted approximately 5 seconds. Injured Paramedic reported being unable to release his grip from either door handle. Injured Paramedic fell from the bumpers, which broke his grip and ended the shock. Injured Paramedic reported felling generally sore and stunned for hours following the incident. Injured Paramedic was sent for evaluation by Physician per the request of his supervisor.	Post-incident evaluation uncovered two unique issues, both significant. The "Auto-Elect" shore line had an internal short which allowed 110V energy to energize the ambulance body. The shoreline itself failed to trip the GFCI when the short occurred. The shoreline had just recently been installed by a licensed electrician and passed a building inspection. Develop a PM schedule for all shoreline components, both fixed and mobile. Per advice of electricians end the practice of contacting two pieces of apparatus concurrently. The body of the Paramedic acted as a conduit to pass energy.
2	BLS team dispatched to provide medical transport from a higher level of care and return patient to rural hospital to continue care. While traveling to the higher level of care hospital the team stopped outside city limits to refuel prior to picking up patient. After fueling team proceeded to hospital. En route to hospital driver was following the flow of early morning traffic in low light conditions. Driver did not initially notice pedestrian enter crosswalk. Crosswalk was at a section of road that did not have stoplights. At last second, the driver noticed the pedestrian and sped up to avoid hitting his brakes and avoid turning into other lane. Pedestrian almost hit by mirror of ambulance. Per driver, additional traffic did not yield to pedestrian either. Team continued to higher level of care hospital to load patient.	Driver reminded to head crosswalks at all times and to keep a safe distance from flow of traffic when possible. Crosswalk can be equipped with red flashing light to notify traffic pedestrian is entering crosswalk. Crosswalk could have been lit better. Pedestrians can be reminded to wear highly reflective clothing. Information can be shared with drivers as a reminder to pay closer attention to crosswalks
3	Truck 1 was dispatched to "stand by" for an "unknown medical event" just outside of the county line on "XX street". The crew was directed by dispatch to stage in the area of "XX street" and no further information was given. While en route, the crew overheard radio traffic that advised PD of a domestic situation with shots fired. EMS was not advised however the crew decided to stage at another location away from the incident due to the new information. Once at the staging point the crew advised dispatch of their new location multiple times and the dispatcher proceeded to inform LE of another separate location a few miles away from the crews actual location. The correct location of the crew was not conveyed to LE at anytime during the call. EMS was also dispatched first (13 minutes before LE) to a known domestic w/ shots fired.	Chain of events, EMS dispatched to a violent scene prior to LE at a rural location, Call was to an "unknown medical", Crew was sent to the location of the shooting to "stage", Dispatch was never able to determine the location of the crew at the staging point. Increased training for dispatchers, Increased communication between all entities.

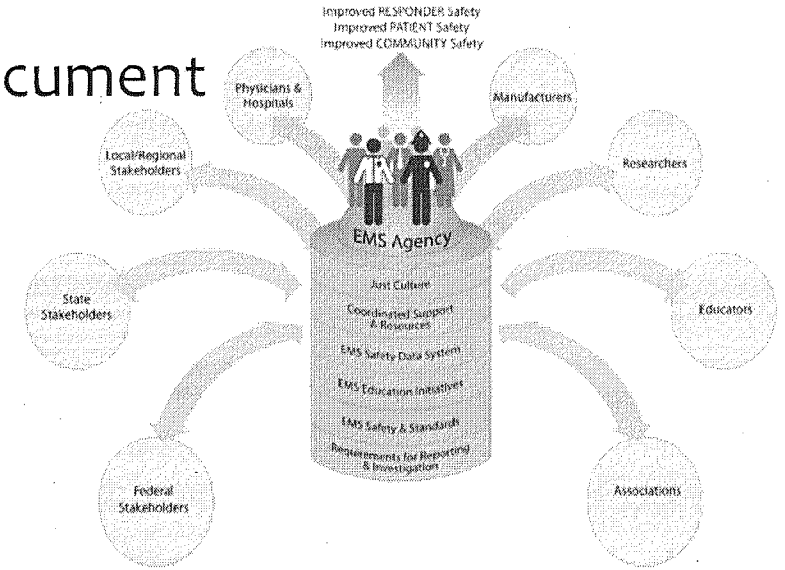
Now What?





* CQI/QA
* Patient Safety Committees
* Simulation-based trainings
* NAEMSP Culture of Safety Document
* Checklists





Now What?

Types of Medical Errors
Typically encountered medical errors can be categorized into three types: procedural, affective and cognitive.7

Procedural error: These occur during technical procedures such as IV cannula insertion or endotracheal (ET) intubation. Individuals who have limited experience with the procedure often make procedural errors. Once the individual is familiar with and repeats the procedure, the rate of error usually decreases. In this regard, procedural error might be mitigated by simulations, supervised practice and/or experience over time.7

Affective error: These occur as a result of emotions, such as assuming a known alcoholic patient is unresponsive because they're intoxicated, when in reality they may have a serious unrelated condition such as a subdural hematoma secondary to trauma.

Because the clinician's judgment is clouded by emotion, the best and most logical course of action may be ignored for something more in line with the emotional response. The potential solution for affective errors is to recognize and be aware of the emotion and act accordingly.7

Cognitive error: Cognition is the scientific word for "the process of thought." Thus, cognitive errors are made during the thought process. Research into cognitive error has been quite extensive, likely due to its potential for prevention. However, there's still limited insight into specific preventative strategies for cognitive error.

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Home » Training » Prevent Medical Errors in the Field with Cognitive Strategies

Training

Prevent Medical Errors in the Field with Cognitive Strategies

article | comments

Like Share 301 | Share 7 | Pin it | Tweet 9 | EMAIL | PRINT

Aaron K. Sibley, MD, FRCPC | David Fu, MD | Rob Woods, MD, FRCPC | From the December 2014 Issue | Thursday, December 4, 2014

EMS is dispatched to the home of an 82-year-old female with a chief complaint of shortness of breath. On arrival, the crew learns she has had a dry cough for a week and is now complaining of significant malaise and shortness of breath when she lies flat, but denies any chest pain.

On examination, they find her respirations to be labored, but she's not in severe distress. Vital signs are: heart rate of 114 beats per minute (sinus rhythm), respiratory rate of 28 breaths per minute, blood pressure of 154/105 mmHg, oral temperature of 99.5 degrees F, and O2 saturation is 90% on room air.

On auscultation of the lungs, crackles are heard at both bases. Suspecting the patient of having heart failure, the paramedics examine her legs and find mild peripheral edema.

Photo: Don't force pieces of evidence to support your initial diagnosis. Take the time to take into account all vital signs and aspects of the scene. Photo Kevin

Five Simple Strategies to Prevent Cognitive Errors

1. Incorporate simulation into your training plan. Search for places where errors may occur and develop ways to prevent them. Mentally running through a patient encounter can be a good use of brief periods of downtime.
2. Force yourself to consider additional diagnoses. Despite the patient having a classical presentation of diagnosis A, mentally consider possible diagnosis B and C.
3. Be wary of diagnostic labels, especially ones passed on from other healthcare professionals. Being labeled a "psych" patient can have serious consequences if incorrect.
4. Regularly ask for feedback and modify your care based upon it. Contact your medical director to obtain patient information. Find out what happened to patient "A" when you dropped him off in the ED.
5. Use checklists, a handbook or electronic handheld device to decrease reliance on memory. Double check drug doses in this manner whenever possible.

Questions

Event.clirems.org

Garrett Hedeen
ghedeen@gmail.com

E.V.E.N.T.
EMS Voluntary Event Notification Tool
An EMS Culture of Safety Initiative

Attachment #7

James L. Greeson, Indiana State Fire Marshal
Department of Fire and Building Services / IDHS

NFIRS & NEMSIS

Good afternoon, the State Fire Marshal office would like to introduce Angie Biggs as the new EMS/Fire Data Coordinator. Her contact information is as follows. Phone 317-232-2227 Cell 317-509-4157 email abiggs@dhs.in.gov

We are in the process of getting the pilot program ready to launch for National Incident Reporting System (NFIRS) reporting. There will be an attachment with this letter. Please fill this information out and return it to Angie Biggs abiggs@dhs.in.gov once we have everyone's information uploaded into the system we will be in transition for training on the new Image Trend software.

The State Fire Marshal office is hoping the final product of Image Trend for EMS and Fire should be ready for production in the first quarter of 2015.

Information regarding National EMS Information System (NEMSIS) transition to NEMSIS V3 has been updated. Please see dates below.

Planned closure date for receiving Version 2.2.1 data: December 31, 2015
Planned date for Version 3 to "Go Live": July 2015 or earlier
Planned date for all EMS agencies to move to Version 3: January 1, 2016

If you are not sure if the software vendor you are using is V3 compliant you can email Angie Biggs with the vendor name and also doing business as (DBA) she can verify the information per NEMSIS standards.

If you have any questions please contact Angie Biggs at the information listed above or Assistant State Fire Marshal Robert Johnson rjohnson@dhs.in.gov telephone 317-233-0195.

Thank you for your service to the citizens of Indiana,

Sincerely,

James L. Greeson

James Greeson,
Indiana State Fire Marshal

Attachment #8

EMS COMMISSION CERTIFICATION REPORT

Compiled: December 03, 2014

CERTIFICATIONS (12/03/2014)	Total # of Certs	Highest Lvl. Cert
EMS - PARAMEDIC	4224	4224
EMS - ADVACNED EMT	423	389
EMS - EMT	19315	14712
EMS - EMR	5380	5075
EMT - PI	507	N/A
TOTAL:	29849	24400

Q1 - 2014	Count
EMS - PARAMEDIC	68
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	44
EMT - BASIC ADVANCED	0
EMS - EMT	171
EMS - EMR	88
EMT - PI	7
TOTAL:	378

Q2 - 2014	Count
EMS - PARAMEDIC	127
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	80
EMT - BASIC ADVANCED	0
EMS - EMT	475
EMS - EMR	197
EMT - PI	2
TOTAL:	881

Q3 - 2014	Count
EMS - PARAMEDIC	97
-	-
EMS - ADVACNED EMT	232
-	-
EMS - EMT	468
EMS - EMR	66
EMT - PI	11
TOTAL:	874

Q4 - 2014	Count
EMS - PARAMEDIC	0
-	-
EMS - ADVACNED EMT	0
-	-
EMS - EMT	0
EMS - EMR	0
EMT - PI	0
TOTAL:	0

Q1 - 2013	Count
EMS - PARAMEDIC	97
EMT - INTERMEDIATE	2
EMS - ADVACNED EMT (new)	0
EMT - BASIC ADVANCED	18
EMS - EMT	372
EMS - EMR	198
EMT - PI	8
TOTAL:	695

Q2 - 2013	Count
EMS - PARAMEDIC	24
EMT - INTERMEDIATE	2
EMS - ADVACNED EMT *(new)*	2
EMT - BASIC ADVANCED	14
EMS - EMT	525
EMS - EMR	209
EMT - PI	3
TOTAL:	779

Q3 - 2013	Count
EMS - PARAMEDIC	76
EMT - INTERMEDIATE	1
EMS - ADVACNED EMT *(new)*	11
EMT - BASIC ADVANCED	1
EMS - EMT	464
EMS - EMR	93
EMT - PI	15
TOTAL:	661

Q4 - 2013	Count
EMS - PARAMEDIC	74
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	15
EMT - BASIC ADVANCED	0
EMS - EMT	391
EMS - EMR	226
EMT - PI	6
TOTAL:	712

Q1 - 2012	Count
EMS - PARAMEDIC	119
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	43
EMS - EMT	574
EMS - EMR	158
EMT - PI	11
TOTAL:	905

Q2 - 2012	Count
EMS - PARAMEDIC	92
EMT - INTERMEDIATE	7
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	58
EMS - EMT	523
EMS - EMR	199
EMT - PI	12
TOTAL:	891

Q3 - 2012	Count
EMS - PARAMEDIC	111
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	52
EMS - EMT	492
EMS - EMR	144
EMT - PI	4
TOTAL:	803

Q4 - 2012	Count
EMS - PARAMEDIC	79
EMT - INTERMEDIATE	0
EMS - ADVACNED EMT *(new)*	0
EMT - BASIC ADVANCED	13
EMS - EMT	268
EMS - EMR	124
EMT - PI	13
TOTAL:	497

Emergency Medical Services
Provider Certification Report

Date : December 3, 2014 **December 12, 2014**

In compliance with the Rules and Regulations for the operation and administration of Emergency Medical Services, this report is respectfully submit to the Commission at the **December 12, 2014** Commission meeting, the following report of agencies who have meet the requirements for certification as Emergency Medical Service Providers and their vehicles.

Provider Level	Counts
Rescue Squad Organization	3
Basic Life Support Non-Transport	432
Ambulance Service Provider	95
EMT Basic-Advanced Organization	21
EMT Basic-Advanced Organization non-transport	18
EMT Intermediate Organization	13
EMT Intermediate Organization non-transport	0
Paramedic Organization	190
Paramedic Organization non-transport	12
Rotorcraft Air Ambulance	13
Fixed Wing Air Ambulance	3
Total Count:	800

New Providers Since 17-OCT-14

GREENDALE EMERGENCY MEDICAL SERVICE	**Intermediate Certification: 10/30/2014**

Attachment #9

Hilton, Candice

From: Straumins, Alexander
Sent: Wednesday, December 03, 2014 4:17 PM
To: Hilton, Candice
Subject: Commission Report and POST data
Attachments: COMMISSION REPORT(12.3.2014).xlsx

Candice,

Here is the data.
-==========

LMS POST COURSE: (Numbers do not include POST class from EMS-EMT classes)

- Total Assigned to Course: **15,516**
- Total Completed Course: **14,892**
- Total in Progress: **431**

-==========

Certification: "LMS Course: Post Indiana - Physician Orders for Scope of Treatment"

- Persons who currently have the POST Course certification: **15,479**

Number does not include persons who have taken POST course via newer EMS-EMT classes, but have not received their certification from the content in that class.

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Current number of individuals who have received their POST certification from an EMS-EMT class: **23**

Regards,
Alex Straumins